Recommendations of the Special Commission on the Health Care Payment System
July 16, 2009

Appendix E:

Special Commission Meeting Minutes

Special Commission on the Health Care Payment System
Commission Meeting Minutes
January 16, 2009

Meeting Date, Time, and Location

Date: Friday, January 16, 2009
Time: 1:00 – 3:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Guest Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Christie Hager ✓ Nancy Kane ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Bill Ryder of the Massachusetts Medical Society (for Alice Coombs, MD)	✓ Nancy Savoie, Deputy General Counsel at DHCFP ✓ Will Matlack, Assistant Attorney General and Chief of the Anti-Trust Division	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC ✓ Candace Natoli, Mathematica Policy Research

Meeting Minutes

1. *Introduction of Commission members*
    a. The Commission members introduced themselves and identified which organizations they represent.

2. *Commission's role and responsibilities*
    a. Overview of statute (Section 44 of Chapter 305 of the Acts of 2008) - Nancy Savoie, Deputy General Counsel at DHCFP, reviewed the key provisions of the statute that created the Commission (Section 44 of Chapter 305 of the Acts of 2008). Commissioners were reminded that the goal of the Commission is to investigate reforming and restructuring the health payment system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care. The membership of the Commission is legislatively mandated. The Commission is required by legislation to consult with different health care stakeholders throughout the state. Additionally, the Commission was reminded that their meetings are subject to the open meeting law, that six Commission members represented a quorum, and that all actions require a majority vote. The Commission is also subject to the state's ethics laws.

b. Process and expectations

- The Commission's Co-Chairs introduced Michael Bailit, Bailit Health Purchasing, LLC and Bob Schmitz, Mathematica Policy Research (MPR), the contractors hired to assist the Commission in their deliberations. The contractors were chosen through the RFP process. Michael Bailit will facilitate the Commission's discussions, and Bob Schmitz and other MPR staff will work on developing a document that describes health care models and payment reform options. Additionally, the contractors will take on specific assignments from the Commission and draft its findings and recommendations.

- The Commission's co-chairs discussed the timeline for completing the Commission's work. Commission members were reminded that they are being asked to complete their work by May. Because of the tight timeframe, Commission members were asked to either send a designee in their place or call into the meetings if they could not attend a meeting in person. The co-chairs also encouraged open dialog among the Commission members. There was a recommendation that microphones be made available at future meetings and that members bring their lunch to future meetings so that they could work through lunch.

- The Commission will have a website (www.mass.gov/dhcfp/PaymentCommission) where meeting dates, meeting materials and other information would be posted.

- The scope of the Commission's work was also discussed. The Commission is tasked with developing recommendations on provider payment methodologies to be used by all payers in Massachusetts, including Medicare. The Commission will include within its scope hospitals, physicians, and other ancillary services, but will not include long term care and dental services, since Medicaid is the primary payer for long term care. The Commission will not create payment models from scratch, but will be evaluating existing payment methodologies presented by the contractors and other experts. The Commission will evaluate, and may choose amongst different methodologies, or may knit methodologies together. It is currently unclear whether the Commission will recommend one model, or different models that may work for different parts of the health system. The Commission will also discuss both long-term and short-term system changes, as well as the roles of the private market and government. Since the Commission may not have the time to discuss some important issues that would likely be brought up during the meetings, the Commission decided to place these issues in a "parking lot."

c. Anti-trust considerations - Will Matlack, Assistant Attorney General and Chief of the Anti-Trust Division, explained to the Commission members that the Commission's

enabling statute provided specific guidelines on how to deal with potential anti-trust issues that may arise during deliberations. The Attorney General's office will serve two functions with respect to the Commission:

- It will advise the Commission on anti-trust issues that relate to the Commission's recommendations for payment reform.

- It will provide ground rules for the Commission to follow to avoid potential anti-trust issues, given the fact that private sector members will be speaking to each other during the Commission meetings. Specifically, Mr. Matlack indicated that it was permissible for Commission members to discuss payment systems and macro issues, to speak with experts, and to ask private sector entities about their current practices. It is not acceptable for private entities to talk about granular pricing information and for one competitor to know the granular pricing information of another. If the Commission felt it needed granular pricing information for its work, the Attorney General's office would work with the Commission to obtain the information following a mechanism established by federal regulations.

- A representative from the Attorney General's office will attend all of the Commission's meetings.

3. *Payment reform principles*
   a. Michael Bailit facilitated a discussion of payment reform principles. He first asked the members to identify what was wrong with the current health care payment system. The Commissioners identified the following:
      - Fee-for-Service (FFS) rewards overuse; does not encourage consideration of resources; does not align with evidence based guidelines; rewards volume, not quality or outcomes.
      - Variable margins incentivize volume, not value.
      - Caregiver incentives are not aligned among acute care hospitals, behavioral health providers, MDs, etc.
      - FFS does not recognize differences in performance, quality, or efficiency.
      - FFS is hard to administer given changes in health care delivery and technology.
      - The current payment system is byzantine; consumers and providers cannot understand it.
      - FFS is administratively complex.
      - FFS cannot build in cost growth limitation.
      - FFS fees often do not relate to actual costs.
      - There are disparate payments for the same service.
      - Some high-value services are not reimbursed.
      - The current system over-rewards intervention and not cognitive action.
      - FFS is a blunt instrument used to distinguish what services cost and what they ought to cost.
      - Multiple players determine the rates.

- FFS focuses attention on prices and not costs.

b. The Commissioners were then asked to identify desirable attributes of a payment system. The Commissioners identified the following: The payment system should:
   - Be flexible to adapt to changes in medicine.
   - Reward outcomes, not activity – e.g., quality, clinical outcomes, evidence-based adherence, efficiency, patient satisfaction.
   - Be tied to affordability.
   - Consider access – e.g. availability of services, consumer choice; payments should be adequate to elicit sufficient supply of providers.
   - Not drive capacity based on profit goals - prevent more capacity from developing than required for evidence-based care and desired outcomes.
   - Provide consistency of payments across payers to ensure access across the Commonwealth and its populations and payers.
   - Decrease variation in quality and cost across providers.
   - Provide differential payments based on performance.
   - Be fair and transparent.
   - Provide reasonable profit.
   - Not have incentives to take or not take certain patients.

c. This discussion also identified the following "parking lot" items:
   - Consumers should have "skin in the game."
   - The role of benefit design in promoting payment reform.
   - How to finance payment of care, not services (community rating, etc.).

4. *Draft payment reform principles*
   a. The Commissioners were asked to provide input into draft payment reform principles. The changes to the principles discussed by the Commission are summarized as follows with the suggested additions underlined and deletions bracketed:
   b. Base assumption: Significant reform of the provider health care payment system is required to significantly slow the high rate of health care cost growth, <u>while improving quality and appropriateness of care.</u>
      - <u>As currently implemented,</u> fee-for-service payment rewards overuse of services and therefore is not a preferred model for most provider payments.
      - <u>At a minimum,</u> payments should be adequate to cover the costs of efficient providers and ensure adequate access to care for consumers.
      - Provider payment systems should reward <u>and promote</u> the delivery of efficient, high quality health care that aligns with evidence-based guidelines.
      - The health care payment system should reinforce provision of the optimal level of care and care coordination across the spectrum of health care providers.
      - Payments should minimize the risk to providers [for events largely outside of their control] <u>of differences in population health status</u> and should neither reward nor penalize a provider for accepting one patient rather than another (no incentives to "cherry pick" <u>among patients with the same condition or need</u>.)

- Health care payments should be uniform [for specific services – delete], on a risk-adjusted basis, regardless of payer, to the extent that this is financially feasible [for government payers – delete].
- The health care payment system should be organized in such a way as to minimize provider and payer administrative costs that do not add value.
- All team members should share benefits.

c. A revised draft will be provided to the Commission after the staff and consultants have obtained stakeholder input.

5. *Possible payment models*
   a. Bob Schmitz was then asked to briefly discuss the payment strategies outlined in the statute. He indicated that some of these strategies are not payment models, but rather mechanisms to improve care and outcomes that can be combined with payment models to improve care. He described the following payment strategies:

- **Blended capitation**: Blended capitation means different things to different groups. Under Medicare it means a blend of adjustments to a global capitation rate – for example a capitation rate may vary based on geographic, demographic and severity characteristics. Other groups understand it to be capitation payments for one set of services, while another set of services are paid using FFS. A third interpretation of this term involves a capitation payment that is less than the actuarial value of care, augmented by FFS using rates that are lower than typical FFS payments, which combined results in an appropriate rate.
- **Episode of care**: Episode of care payments are represented by a number of different approaches. Generally, they are payments that are paid for a specific event and the services that are provided around that event – for example, heart attacks and hip replacements. The most well known episode of care model is the Prometheus payment system.
- **Medical homes**: The medical home model is an approach whereby a provider, typically a doctor, receives a payment for monitoring and coordinating care for a patient throughout the system. Often a primary care physician will provide primary care services and coordinate and monitor the other types of care.
- **Global budgets**: Global budgets are not a payment system. Rather they are a mechanism whereby an authority sets a budget for all services. Canada and the United Kingdom (UK) use this strategy. Payment to providers can vary within the global budget system. The term "global payment" is a different concept in that it means an entity is accepting one payment for all the care it provides.
- **Pay-for-performance**: Pay-for-performance (P4P) is a system whereby providers receive additional payments or bonuses for achieving outcomes or quality measures. P4P can be combined with a variety of payment approaches.

- **Provider tiering**: Provider tiering designates providers into different categories, usually based on efficiency – patients can be incentivized to use providers that are part of a preferred tier.
- **Evidence based purchasing strategies**: Evidence based purchasing strategies are strategies whereby an entity assesses devices, procedures, technologies, or medications for their effectiveness. The Centre for Evidence-based Purchasing in the UK uses this strategy. These organizations can issue reports to payers, which can then use the information to make benefit coverage and reimbursement decisions.

b. Mr. Schmitz indicated that all payment strategies will require some sort of risk adjustment, and that many of these systems and strategies can be combined to improve quality of care. He also recommended that the chosen system(s) must be able to respond to changes in covered services and address care outside of Massachusetts, and will have to be monitored and updated, and be flexible enough to be modified.

6. *Proposed work plan*
   a. The co-chairs proposed convening a working group that would meet in the next few weeks to designate agenda topics and guest speakers. There is a limited budget to pay for travel expenses for guest speakers.

   b. The co-chairs added another Commission meeting in February as an opportunity for members of the public to offer their perspectives. In addition, there will be three rounds of stakeholder engagement. The first round, which will be in February, will gather feedback on the discussed principles. A second round in April will gather feedback on the strengths and weaknesses of payment models. The third round will obtain feedback on the draft recommendations in May.

7. *Next steps*
   a. The next meeting will focus on two models: episode-based payment and medical homes. MPR will synthesize the basic features of these models, summarize implementation strategies, and provide a complete literature review of the topics. Michael Bailit will present on the medical home. There will also be a guest speaker to present on episode-based payments.

   b. Several Commission members expressed an interest in using the Commission meetings primarily for discussion and questions. The recommendation was also made to ask providers that are living with the proposed systems to present.

   c. Regarding the public meeting to obtain stakeholder feedback, it was recommended that testimony be invited and that witnesses provide something in writing to the Commission before the meeting. Also it was recommended that the Commission make it clear that it was tasked with reforming payment, not insurance reform. The structure of this meeting will be discussed early next week, and will likely be scheduled in early February.

d. It was also requested that the Commission members be provided with information on how the delivery system is currently organized and how health care dollars are spent in Massachusetts.

The meeting was adjourned at 2:50 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 6, 2009

Meeting Date, Time, and Location

Date: Friday, February 6, 2009
Time: 12:00 – 3:00 p.m.
Place: Gardner Auditorium, State House Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas	✓ JudyAnn Bigby, MD ✓ Lucian Leape, MD ✓ Alan Sagar ✓ David Matteodo ✓ Ellen Murphy Meehan ✓ Marylou Buyse, MD ✓ Rick Weisblatt, MD ✓ Marc Spooner ✓ Antonia Blin ✓ Gerry Steinberg, MD ✓ Brian Rossman	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC

Meeting Minutes
Co-Chair Kirwan summarized the importance of the Payment Commission's work by reminding attendees that to sustain universal health insurance coverage health care costs must be contained. The Commission will be developing both short-term and longer-term implementation strategies. She welcomed input from all stakeholders and that obtaining input was an important part of the Commission's responsibilities.

Co-Chair Iselin explained the process for today's meeting, which is dedicated to receiving input from stakeholders. Those who had not signed up in advance were invited to speak. All speakers were asked to limit remarks to 5 minutes. All written comments will be shared with the Commissioners and will be read. After each speaker's presentation, Commissioners will be offered an opportunity to ask questions. The Commission will receive written presentations until February 11. Attendees were advised to go to the Payment Commission's website for instructions.

1. *JudyAnn Bigby, MD, Secretary of the Executive Office of Health and Human Services*
    a. The Commission has an opportunity to think big to reach the Commonwealth's goals of improving cost, quality and equity.
    b. Consider an all-payer system that has the same payment rates and methodology for all providers. This includes higher payments for Medicaid to avoid cost shifting.
    c. Protect safety net providers by giving them additional payments.

d. Include public and private payers collaboratively.
e. Use an episode of care payment system for providers, adjusted for case complexity. Provide additional payments to teaching hospitals to cover teaching costs.
f. Build in accountability for care over time, which is associated with higher quality and lower costs.
g. Increase payments to PCPs to recognize the value of preventive services. Pay for services not historically reimbursed, including care coordination. Reward providers for providing patient-centered care.
h. Have a fully vertically and horizontally integrated system with the patient having multiple connecting points.
i. Promote coordination across delivery groups.
j. Include Computerized Order Entry Systems with full interoperability.

k. Commissioner's Questions:

Question	**Response**
How can we get to a virtually integrated system of providers starting from where we are now (with lots physician practices of 1s and 2s)?	Possibly create a regional coordination center that would provide the type of support available in larger group practices. Groups could share back office and other systems.
Should case mix adjustments be made pre-service or at the end of the year?	Either might be acceptable.
How should we deal with providers who will not take certain types of insurance or will only take cash? What about concierge practices?	This is a question of how much tolerance there should be in the redesign for individual decisions. Rates should be more equal so that there is no reason not to accept Medicaid
If there is a state authority with oversight responsibilities, do you envision a work-around for Medicare or every payer using the same songbook?	I am thinking about a CMS waiver.
Do you see the PCP as gatekeeper in a positive way to achieve a patient-centered approach?	PCPs must support and advocate for the patient. The key is an episode of care payment, which would require providers to work in integrated systems.
What ideas do you have to restrain the growth of high fixed cost technologies, which create volume incentives?	We would need to evaluate what is needed regarding health planning, including comparative effectiveness evaluation.
Do we have enough resources in the system to fund the changes you are discussing?	We currently have enough resources to make an orderly transition. Interim steps to strengthen primary care, and provide P4P incentive systems on top of the current FFS system have had mixed results. We need to look at a whole system redesign.

2. *Lucian Leape, MD, member of the Harvard Medical School Faculty, speaking as an individual*
    a. Following are the key points made by Dr. Leape:
        - It is not enough to bend the curve; health care costs must be reduced.
        - Overuse and under use are the two causes for increased health care costs.
        - The answer is to work in teams. Pay for care in an integrated way by doing the following:
        - Pay for care not for services
        - Pay for groups of providers, not individuals. PCPs, specialists, social workers, etc. must work together to provide better care for individuals.

    b. Commissioner's Questions:

Question	Response
How would you account for differences in the quality of provider practices in a payment system?	Hold groups accountable for outcomes. Leave it to the group to figure out how to get to outcomes. Physicians are able to get together, figure out how to get quality care and to police themselves.
What innovations would you suggest to bring small practices of 1 and 2 physicians into a group mode?	EMR is one way to link people to a common set of standards and practices. Doctors must be told that they must come together and work as a team.
What structure would you suggest to change the current culture and stop the introduction of new technology, even before its value is proven?	Establish a federal board to assess the cost and effectiveness of new technologies. We need to make decisions regarding what works and only pay for what works.
Sometimes people working in teams, not the payment system, result in better decisions, including reviewing cases retrospectively to learn from different situations.	I agree.

3. *Alan Sager, Professor, Health Policy and Management, Boston University*
    a. Following are the key points made by Professor Sager:
        - There is enough money in the system to provide quality health care services for everyone.
        - Massachusetts spends 1/3 more per person ($11,100) than the national average.
        - All efforts to date have not controlled health care costs. Containing costs is a retail job requiring the active, motivated involvement of enthusiastic physicians.
        - Recommendations: promote the medical home concept, eliminate defensive medicine, eliminate unnecessary paperwork, create a full frontal capitation of $8000 per person, risk adjusted. Put the funds into

three watertight buckets for primary care, specialty care and all other care.

b. Commissioner's Questions:

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
Please explain the $700 million.	There are about 6.4M people in Massachusetts. If we want the patient panel of each primary-care physician to be 1,000 on average, then we require 6,400 primary-care physicians. If the average pay of a primary-care physician is $110,000, then the total annual payment for these physicians is about $700 million.
Were hospitals included in your calculations?	They were not included.
How can you change the dynamic of medical students not going into primary care because of prestige and other less tangible issues?	There is a need to recognize the difficulty of the job and the variety of strengths required to do it well to increase the prestige of this area of practice.
What is your reform suggestion?	Bundled payments, a governmental entity to evaluate effectiveness of technology and services, but a voluntary system to measure outcomes.
How are PCP's salaries increased?	Adopt a medical home model with capitated payments in the amount of $8000 per person, risk adjusted. Then divide funds into three watertight buckets – PCP services, specialty services, pharmacy and everything else. Dental care and OTC drugs are not included. Physicians can decide how they want to be paid. I want doctors to concentrate less on their own incomes and more on what they can control.
How do you define self-regulation? Seems to me that government must set standards of performance.	There must be a mixture. Initially physicians would volunteer and do what is best for the patient by practicing evidence-based medicine. We would learn from their experience. Regulations could track adherence to EB standards and horizontal equity (patients being treated the same).
Are hospitals covered by the $8000 capitation?	Pay hospitals on a prospective basis. Physician groups would buy hospital care to mimic the free market.

In England there are 75% PCP and 25% specialists, which is the opposite from the US. How can we get there?	No answer.

4. *David Matteodo, Massachusetts Association of Behavioral Health Systems*
    a. The following are the key points made by Mr. Matteodo:
        - Inpatient mental health and substance abuse facilities are a small but significant part of the health care system. 75% of income is from a public payer.
        - We need a payment system with the following characteristics:
        - Predicable and understandable.
        - Incentives are aligned with good patient care. Currently there are increasing pressures for short lengths of stay. We want to give patients what they need.
        - Appropriate oversight for treating clinicians. Currently authorizations from MCOs take hours. Once the patient is admitted there is continuing second-guessing by MCOs.
        - Increase deeming opportunities with respect to credentialing organizations.
        - No additional unfunded mandates. Additional requirements must come with additional funding in this fiscal crisis.
        - State agency requirements must be taken into consideration. Currently DMR and DCF agencies have administrative days. The children get stuck because of no appropriate placements; we receive a reduced payment, but the child continues to get the same level of care. This in turn keeps kids in the ER, instead of inpatient placement. These problems may increase with state hospitals closing.
        - Be sensitive to fixed costs and on-going costs. In FY09 there was no MassHealth rate increase, but our costs are continuing to increase.

    b. Commissioner's Questions:

The following summarizes the Commissioners' questions and the speaker's responses:

Question	**Response**
Which payment system would be best for behavioral health services, and to encourage integration of behavioral and all other health services?	Behavioral health must be integrated into incentives. Often a PCP doesn't know that a patient is in a psych hospital. A payment system must support stronger inter-relationships.
The current system does not recognize the complexity of these patients, particularly in the ER.	The most important thing is to change the situation in the ER. ER waits for an inpatient bed should be limited to 24 hours. We need quicker authorizations.

5. *Ellen Murphy Meehan, Alliance of Massachusetts Safety Net Hospitals*
    a. Following are the key points made by Ms. Meehan:

- Low-income patients rely on safety net hospitals. These hospitals are paid less. The quality of care is different. Access to capital and the physical plants are unequal. Access to specialists is unequal. They also provide additional unreimbursed services, including translation, and social services.
- We try to grow PCP practices, but it is hard to compete with other facilities receiving higher payments.
- We are concerned that we will be left behind in payment reform.
- We had hoped that under health care reform we would have received more dollars. They went to the teaching hospitals because of the criteria used. We have seen our rates decline through health care reform. We provide much more outpatient care to uninsured people than do teaching hospitals.
- A 25% add-on has been endorsed to remedy the problem. We would like this to remain. Payment reform must consider these hospitals. Flexibility is needed to save these hospitals. Payments must cover costs.
- These hospitals do not have access to low-cost capital to buy EMRs.
- These hospitals do not have control over the largest physician practices in the area, because they are attached to tertiary hospitals.
- A new payment system must have the following features:
- The cost of care is covered by the payment levels.
- It must adapt to the type of patients served.
- It does not perpetuate inequities that exist today.

b. Commissioner's Questions:

Question	**Response**
What type of payment system would be best for your hospitals?	A system that creates a level playing field in the short run.
In the long run would an all payer system with the same level of payment work for your hospitals?	The same level of payments won't work. We have no EMRs; our facilities are old. We need extra dollars to get even.
Why do lower income patients go to DISH hospitals when other hospitals are available?	These hospitals understand this population and serve them well. Serving them is part of their mission. Others don't want to care for people who pay them less.
Is the problem one of poor distribution? Is there enough money in the system to provide the necessary care for everyone?	I cannot answer this question. I ask the Commission to look into hospitals spending money to move into well-to-do suburbs and whether the dollars could be used better. Possibly incentives could be provided to hospital workers to receive the care at the hospital where they work.

6. *Marylou Buyse, MD, Massachusetts Association of Health Plans*
    a. The following are the key points made by Dr. Buyse:
        - Keeping health care costs affordable is challenging to all.
        - All can benefit from reforming the health care system, leading to better coordination of care and improved quality.
        - Reform should recognize:
        - Cost control should result in lower costs for consumers and payers.
        - One size does not fit all.
        - It takes time to implement reform and requires interim steps. Most providers are not in positions to implement needed change.

    b. No questions were asked of Dr. Buyse.

7. *Rick Weisblatt, MD, Medical Director for Behavioral Health and Pharmacy, Harvard Pilgrim*
    a. Following are the key points made by Dr. Weisblatt.
        - Tufts Health Plan has 80% of its PCPs either under risk contracts or eligible to receive P4P payments, which represents 80% of our members.
        - 18 months ago we included hospitals in our P4P program.
        - We have incentives regarding infrastructure, quality and efficiency.
        - We have seen improvements in all domains (citing statistics over a 2 or 3 year time period).
        - The keys to a successful P4P program include:
        - A long-term strategy to engage leadership, provide practice support and use nationally accepted measures. Physicians can be well organized in small practices with 1 or 2 physicians.
        - If all payers used the same measures, it would have an impact.
        - Some of the issues that must be addressed.
        - We are just starting with efficiency measures, and are just at the tip of the iceberg.
        - There are few specialists' measures.
        - P4P does not change FFS incentives.
        - P4P is not applicable to PPO and self-insured accounts.

    b. Commissioner's Questions:

Question	Response
What percent of total payments are P4P incentives?	Between 5 to 10%.
We need to share information to get a bigger penetration and make a bigger impact on a physician's practice.	With enabling infrastructure, we would be happy to participate. You must have Medicare as a player. Without them 50% of a physician's practice is off the table.
Do you see a need to move away from a	Yes. Physician group should be able to tell

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Question	Response
FFS model to get at delivery issues and bring about reform?	plans what payment methodology they want. We need options for smaller groups. Risk adjustments are needed.
MassHealth is the payer that is most unlike other payers.	When we went to hospital P4P, we used CMS measures and reports. CMS can drive change.
What are the three lessons learned that you could share?	1. All parties must be engaged in the beginning. Use a collaborative model. 2. Leadership and infrastructure within practices is key to bringing about practice pattern changes. 3. All payers must be involved and using the same methodology and approach to payment.
How should we pay for big-ticket items such as use of ICU at end of life situation?	P4P needs to be based on consensus. There is no consensus regarding end of life. P4P must be easy to implement. There is no precedent regarding an end of life case. Reform of practice of medicine must come from medical practitioners.
Do you think that episode of care payments might bring about the behavioral change we are looking for?	It depends on who is involved in the capitated group. A PCP under capitation could not impact behavioral of oncologists. Maybe prospective payments would be better. This is why we need a range of approaches to bring in hospitals and specialists.

8. *Marc Spooner, VP of Provider Contracting at Tufts Health Plan*
    a. Following are the key points made by Mr. Spooner:
        - Tufts Health Plan has extensive experience with capitation in its Medicare Advantage product.
        - Capitation has been criticized for inappropriately rewarding under utilization. Our experience is that this is mitigated by use of disease management programs.
        - Providers who are willing to take on a risk-based contract have infrastructure to control referrals, and they must be willing to manage care by engaging patients in difficult conversations.
        - Tufts Health Plan provides support to providers by sharing best practices and analyses of practice patterns.
        - For capitation to work in a commercial environment, there are three determinative factors:
        - Whether the provider has capital and the infrastructure to manage care.
        - Whether a sufficient scope of services are provided at the home hospitals using local specialists.

- Whether there is a sufficient degree of integration between the physicians and the home hospitals. There need to be conversations about sharing financial risk with the hospital.
- View capitation as an option, not a panacea.

b. Commissioner's Questions:

The following summarizes the Commissioners' questions and the speaker's responses:

Question	Response
How can we change the cultural issues around patient expectations?	Patients are used to easy referrals. It is time to open conversations with patients.

Dr. Buyse offered to share with the Commission a paper on cultural issues regarding Americans and health care.

9. *Antonia Blin, Massachusetts Association of School-Based Health Centers*
   a. Following are the key points made by Ms. Blin:
      - 25 different organizations coordinate to provide services in 62 different centers.
      - A variety of organizations would be impacted by reimbursement changes.
      - School-based health centers are convenient, cost effective. They are run by nurse practitioners.
      - Prior authorizations are barriers to the Centers receiving necessary financial support. Easy referrals should be available when services are provided in a confidential way to high-risk young men and women.

   b. Commissioner's Questions:

Question	Response
What key message do you want the Commission to hear?	Do not forget about us as part of the heath care system. We can play a bigger role in providing cost-effective, high quality care. Students are getting care when and where they need it.

10. *Jerry Steinberg, MD, Chief Medical Officer and Quality Officer at Cambridge Health Alliance*
    a. Following are the key points made by Dr. Steinberg:
       - CHA is a DISH hospital and we care for a large number of patients with behavioral health issues. We have seen an increase of 80,000 visits.
       - Payment reform must address the disparity in reimbursement across provider types and services. Payments for behavioral health services do not cover costs, and there is a need to level the playing field.

- Payment reform must be a primary care based system that promotes cost effective, high quality services.
- Reforms must promote stronger team-based primary care with mental health and shared responsibilities.
- We must transition from volume to value.
- We must align financial incentives with the goals of promoting prevention, optimal utilization, wellness and best outcomes.
- Optimal utilization must reside within the work of providers. It cannot be based on authorizations.
- There must be enhanced payments for primary care, chronic care management, mental health and substance abuse services.
- CHA has had experience with team-based models for management of chronic diseases with positive results. Currently care coordination, improved access, group visits, and outreach to hard-to-reach patients are not reimbursable service.
- CHA has some needed infrastructure to manage care. We are interested in being a demonstration partner.
- Graduate Medical Education payments should be directed towards primary care. We also need post graduation support. Payments need to be focused on outpatient educational services.

b. Commissioner's Questions:

Question	Response
Why do insurance rates continue to increase, and why does hospital bad debt not decline with more people insured and payment for care received?	Lots of work needs to be done on the provider side to meet the goals set out.

11. *Brian Rossman, Health Care For All*
    a. Following are the key points made by Mr. Rossman:
        - Health reform must have the following characteristics:
        - Be like Snow White – be transparent. Payment must be transparent and open so patients can see the incentives for providers and plans.
        - Be like Dumbo – recognize patient empowerment. We need to be aware that the patient needs to be more involved. There need to be decision-making aids so that patients can understand their options, and chronic disease self-management skill development.
        - Be like Goldilocks – it needs to get the size right. It needs to use validated methodologies for risk adjustments.
        - Be like Little Red Riding Hood – recognize the role of public health in payment reform. Some areas, such as translation services, might not be appropriate for payment reform, and should be paid with public health dollars.

No questions were asked of Mr. Rossman.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 6, 2009

The session ended at 3:10 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 13, 2009

Meeting Date, Time, and Location

Date: Friday, February 13, 2009
Time: 11:00 a.m. – 2:00 p.m.
Place: Two Boylston Street, Boston, MA 02116

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Deborah Chollet, Ph.D., Mathematica Policy Research, Inc. ✓ Chris Koller, RI Health Insurance Commissioner ✓ Suzanne Felt-Lisk, Ph.D., Mathematica Policy Research, Inc.	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC

Meeting Minutes
Co-Chair Leslie Kirwan introduced Representative Harriett Stanley, Chair of the Joint Health Care Financing Committee, as the new member of the Commission. She identified the three payment models that are the topics of today's meeting: Patient-Centered Medical Home (MH), Pay-for-Performance (P4P), and global capitation.

Co-Chair Sarah Iselin reminded the attendees that Commission materials are available on the Commission's website. The next Commission meeting will be February 24 from 2pm to 5pm. Two speakers and topics have been confirmed. Glen Hackbarth and Harold Miller will be presenting on episode-based models. There will also be a presentation on evidence-based coverage. Materials will be sent to the Commission members in advance.

1. *Report on stakeholder meetings – Michael Bailit, Bailit Health Purchasing*
    a. Michael Bailit, who was joined by Commissioner Iselin and by members of Secretary Kirwan's staff, reported meeting with the following stakeholder groups:
        - Physicians: specialty societies, large independent physician groups, and groups affiliated with hospitals;
        - Hospitals: community hospitals, teaching hospitals and large safety net hospitals;
        - Consumer advocates;
        - Organized labor groups;
        - Health plans, and

- Community health centers.

b. In addition he has met with the Commonwealth Health Insurance Connector and briefed the Cost Containment Committee of the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board. He will be meeting with employer representatives and EOHHS representatives in the future.
    - The purpose of these meetings was to provide background about the role of the Commission and to review the payment reform principles being developed by the Commission.

c. Mr. Bailit identified several key points of understanding that the attendees took from the meeting:
    - Terminology can be an impediment to communications. For example, the term "provider" means different things to different stakeholders.
    - All stakeholders understand the difficulty of this endeavor. They also acknowledge that payment reform alone is not enough to address all issues driving up health care costs and that there is no guarantee of success.
    - Several stakeholders thought that a vision statement regarding desired outcomes should be added to the principles.
    - Many stakeholders believe integration of the delivery system will provide better value; there is disagreement as to whether real or virtual integration will be necessary to achieve the goals of the payment reform.
    - All affirmed the importance of broad stakeholder participation in this process.

2. *Review of proposed revised payment reform principles – Michael Bailit, Bailit Health Purchasing*
    a. Mr. Bailit identified new concepts to add to the statement of principles as a result of the stakeholder meetings. Suggested additional are the following:
        - No one-payment model will work for all providers or in all regions of the Commonwealth due to the heterogeneity of the delivery system.
        - Payment reform must address the problem of a shortage of primary care physicians.
        - Payment report should seek to balance payments for cognitive, preventive, chronic and interventional care, and be sensitive to the current cross-subsidization occurring within provider organizations as a result of the lack of balance.
        - Implementation should be phased in with time and resources dedicated to evaluation, identification of unanticipated consequences, and mid-course corrections.
        - Payment methodologies should be transparent to all, including patients and providers.
        - Payment reform must be designed with an awareness of the interactive effects of payment model with delivery system organization and with health benefit design.

- Risk adjustment must contemplate not only differences in health status, but in socio-economic status, since lower income groups tend to have lower levels of adherence to clinical instruction.
- A second round of stakeholder meetings will be held following the Commission's fifth meeting.

b. Commissioners' Questions:

Question	Speaker's Response
Were there any objections expressed to moving away from a fee-for-service payment methodology?	Most agreed there was a need to move away from FFS. Some wanted to keep a modified FFS methodology on the table.
Was there any sense of urgency among the stakeholders	No. The sense of urgency was conveyed by the State to the stakeholders. In general, stakeholder's perceived great opportunity coupled with a sense of trepidation regarding potential risks.

It was noted that even if the Commission wanted to move away from FFS, there might continue to be a place for FFS as a way to encourage more of something that the system wants to promote.

3. *Overview of payment models – Deborah Chollet, Mathematica Policy Research*
   a. Dr. Chollet provided the following overview of payment models. Payment models aggregate payments at different levels. FFS pays at the service level. Episode-of-care models bundle groups of services (including physician and facility services) as a basis of payment. Global payment models bundle payments at the patient level. As bundling increases, there is more financial risk to the providers receiving the payment. Quality incentives tend to be in the form of bonuses for meeting quality/value targets.

   b. Dr. Chollet summarized the characteristics of five payment models as follows:
      - Fee-for-service
        - Providers are paid for individual services performed.
        - Payments may be charge based, cost based, or prospective
        - If payments are prospective there is no incentive to increase unit costs, but there are incentives to increase the volume of services and provide more costly mix of services.
      - Pay-for-Performance
        - P4P is usually built on a FFS base. P4P increases payments for improved processes of care that are evidence based and for occasionally for improved quality outcomes.
        - The goal of P4P is to improve quality and effectiveness. It has not been proven to save costs.
        - Payments are usually low and there are lots of different measures used by different payers, so the effect of P4P is muffled and it is hard to know what is achieved.

  - P4P does not necessarily counter the incentives of the underlying payment system. Payments would have to be large to do so.
- Episode of care payments
  - Payment model provides prospective payments for a clinical episode of care. Payments may be risk adjusted.
  - It is in the early stages of development, and is usually developed around specific diagnoses.
  - There is some provider risk, but it is limited to the cost of care, not the occurrence of the episode.
  - There are incentives to constrain unit costs, volume and service mix.
- Global Payments
  - Global payments are fixed payments per patient per month for some or all of the services provided. The difference between partial and full global payments is the range of services for which the provider is responsible.
  - There is high provider risk for both cost of services and occurrence of need for services.
  - There is a strong incentive to constrain unit cost, volume and service mix.
  - Global payments may be adjusted for severity or performance.
- Medical Home
  - This model focuses on primary care, disease management and care coordination.
  - There is a basic and an advanced model. The basic model focuses on care coordination with the patient. The advanced model includes DMR, e-prescribing, performance reporting and care coordination.
  - The Medical Home can be built on any payment model.
  - The Medical Home is a way of approaching the patient, rather than a different payment system.
  - There is no evidence of reduced costs.
- Dr. Chollet offered the following check list of major payment systems issues to consider when evaluating different payment models:
  - How does the payment system perform regarding incentives for patient selection and access to care?
  - Does the system have anything to encourage improvement in quality, and short-term costs.
  - Does the system have an impact on the longer term cost trend, which includes unit cost, volume and service mix?
  - Are the risk-bearing entities stable? How are downstream risks reported and regulated by the state insurance department.

4. *Presentation regarding medical home – Michael Bailit, Bailit Health Purchasing*
   a. Mr. Bailit provided background on the development of the Patient Centered Medical Home (MH). The business case for the MH is based on research that demonstrates that health systems that are primary care focused generate lower

cost, higher quality and fewer disparities than do systems that are specialty focused. The US has a specialty care focused health care system. Other research has evaluated the Chronic Care Model, which is the chassis for much of the NCQA standards, and the research found improved quality. Fewer evaluations have been done on cost and utilization, but most have been positive. The shortage of PCPs will continue without change.

b. MHs have eight distinguishing characteristics:
    - Personal physician/clinician;
    - Team-based care;
    - Proactive planned visits instead of reactive, episodic care;
    - Tracking patients and their needed care using special software (patient registries);
    - Support of self-management of chronic conditions;
    - Patient involvement in decision making;
    - Coordinated care across all settings, and
    - Enhanced access.

c. Currently, there are many pilots and demonstration projects across the US. There are two reasons why the MH pilots involve payment reform: practices are asked to perform more services that traditionally are non-billable services; and there is a need for incentives to move from volume based to quality based practices.
    - There are eight payment models across the US; most are built on a FFS model:
        - FFS with discrete new codes for traditionally un-reimbursable services;
        - FFS with higher payment levels for standard billing codes;
        - FFS with lump sum payments to cover additional costs of redesigning the practice;
        - FFS with a separate PMPM fee;
        - FFS with a separate PMPM fee and with P4P bonuses;
        - FFS with a PMPY payment;
        - FFS with lump sum payments; P4P and shared savings, and
        - Comprehensive payment with P4P (risk-adjusted PMPM comprehensive payment covering all primary care services)

d. Payment amounts typically range between $2.50 pmpm and $5.50 pmpm. The CMS demonstration project will pay considerably higher: tier 1= $27.12/$80.25 and Tier 2 = $35.48/$100.35.
    - Mr. Bailit identified two possible paths for Massachusetts:
        - Sponsor a multi-payer demonstration across the Commonwealth with participation of all major insurers and MassHealth, and of a diverse range of primary care practices. This model is attractive, but its value has not yet been sufficiently demonstrated as a means to reduce costs.
        - Implement the medical home statewide with all primary care practices in a phase-in process. It is clear that the system needs to

be rebalanced to better emphasize, support and reward primary care, and the existing evidence is adequate to support the investment.

e. Commissioners' Questions:

Question	Speaker's Response
Does this system have any accountability for controlling costs outside of the medical home?	There is some indication that the MH system can control costs, but there are no explicit incentives to do so.
How are these systems financed?	Most are demonstration projects that have built in evaluation. Most of the dollars are investment dollars whereby payers are investing in a promising model upfront and then evaluating the results.
Are ER costs included in model 8?	No, but bonus payments look at efficiencies, including the use of ER.
Can this model be applied to smaller practices? Is there a critical mass that is needed?	It is harder for smaller practices. Some demonstration projects have tried to address this issue by creating shared resources for care management services.
Can this model be applied to employed practices?	Yes.
Do participants already have infrastructure in place?	No. PCPs uniformly want to participate in demonstration projects. There is no hesitation because of the short-term nature of a demonstration project. Enhanced fees are a draw. Others are drawn to the model.

5. *Medical home case study presentation – Chris Koller, Rhode Island Health Insurance Commissioner*
    a. Mr. Koller presented an overview of the medical home initiative in Rhode Island being facilitated by his office.
        - CSI Rhode Island is a statewide, multi-stakeholder collaborative designed to align quality improvement goals and financial incentives among RI's health plans, purchasers and providers, in order to develop and support a sustainable model for the delivery of chronic illness care in primary care settings. It provides enhanced payments to PCPs for the delivery of high quality chronic illness care and establishment of a "Medical Home" based on NCQA standards. It is a two-year pilot that began on October 1, 2008. Harvard School of Public Health will be evaluating the pilot.
        - Underlying principles recognize that improving chronic illness care requires re-design of the delivery system. For successful delivery system change there must be external standards and training; incentives and disincentives aimed at the provider site must be aligned across payers, and there must be measurements. RI believes that it must be piloted first.

- RI believes that it must be an all-payer initiative in order to make the numbers work for the practices so that there are enough dollars and patients and required standards to bring about change.
- Participants include:
  - Payers – all except Medicare.
  - Purchasers – the two largest private sector employers, RI Medicaid, State employees, and RI business Group on Health.
  - Providers – the largest PCP organizations (including community health centers and hospital based clinics), RI Medical Society, RI AAFP and RI ACP.
  - State – Office of the Health Insurance commissioner, Department of Human Services and Department of Health.
- The Commitments from each participant are as follows:
- Providers – implement components of the NCQA PPC standards; participate in the local chronic care collaborative; submit self-measurement and public reporting, and provide patient engagement and education.
- Plans – pay a supplemental $3pmpm; pay the costs of the nurse care managers who are allocated across the sites, and provide shared data and common measures for UR measurement and feedback.
- Self-insured employers – pay for programs for their workers.

b. Elements of the CSI RI Pilot are as follows:
   - Common practice sites: all payers will select the same core group of practice sites in which to administer their pilot. This requires a common set of practice qualifications. CSI involves 25,000 covered lives; 28 physician FTEs, and a range of practice types.
   - Common services: all payers will agree to ask the pilot sites to implement the same set of new clinical services, drawn from the PCMH Principles. Sites must achieve NCQA PPC level 1 in 9 months and Level 2 in 18 months. The nurse case manager is hired by the practice, which works with all patients. Payers pay the cost.
   - Common Conditions: pilot sites will not be asked by payers to focus improvement efforts on different chronic conditions. CSI RI addresses coronary artery disease, diabetes and depression.
   - Common Measures: all payers will agree to assess practices using the same measures, drawn from national measurement sets. Measures include structural measures (NCQA PPC-PCMH); outcome measures for three chronic conditions (from practice self-reporting), and cost and utilization measures (ER, pharmacy, IP admission from claims).
   - Consistent Payment: the method and intent of incentive payments will be consistent across all payers. Payment is $3.00pmpm, plus cash to support the care managers. Plans and providers agreed to a common member attribution methodology.

c. Mr. Koller identified the following barriers to convening a broad stakeholder coalition to pilot new payment models:
   - Large national payers have little incentive to participate in regional or state-level programs;
   - Payers fear losing competitive advantage and are not accustomed to collaborating with other plans;
   - Anti-trust concerns;
   - Medicaid and commercial plans are often not aligned;
   - Need Medicare to participate to cover all patients;
   - The PPO and FFS mindsets are diametrically opposed to this approach;
   - Hard to decide what success looks like;
   - The need for a positive ROI must be balanced with "Just Do It";
   - Planning and implementation requires staff time, getting private practices to do non-reimbursed work and death by a thousand unforeseen cuts, and
   - Trust.

d. Mr. Koller also identified the following opportunities to convening broad stakeholder coalitions:
   - The government serving as convener provides both a stick and the anti-trust soother;
   - Engaging major purchasers as advocates;
   - Engaging consumers to be advocates;
   - Developing physician leadership and collaboration;
   - Educating stakeholders regarding the need for delivery system-level reform;
   - Increasing awareness of conflict between medical home model and the dominant PPO benefit plan models;
   - Participating in national PCMH efforts, and
   - Greater alignment in PCP contracting beyond this project.

e. Commissioner Questions and Comments:

Question and Comments	Speaker's Response
Do you see mandating this model statewide in the future?	We won't wait until the pilot is done to move forward. I am already talking with insurers about Phase II to roll out the model more widely.
Do you envision national plans pulling out because of this initiative?	No
Have the practices expanded access?	We are using NCQA standards and expanded access is not required until level 3.
Were the practices volunteers or were they targeted.	They were targeted and represent practice leaders who are affiliated with the largest IPA, large PCP group practices, and the most progressive health center.

Question and Comments	Speaker's Response
What is your strategy to increase the amount of money paid into primary care?	We are holding health plans accountable to report publicly on costs. I am working with separate Advisory Council to develop standards of affordability that plans can implement themselves. One standard is to increase the amount of dollars going to PCPs. It remains to be seen how it will play itself out.
Is there any additional money to cover the costs of installing EMRs?	No. This project assumes either you have one or can find the money to cover these costs.
How do you define EMR?	NCQA does not require an EMR. Practices can use paper tracking systems.
What are your observations about EMRs?	Practices without them have a harder time meeting NCQA standards.
What are the demographics of the population served by the health center?	The health center is in Woonsocket, which is a very economically stressed area. The health center has strong leadership.
How did you decide on a 2-year pilot and what is next if the evaluation is not definitive?	I do not expect the evaluation to be definitive, rather it will be directional. Two years was selected because it was doable for the plans. My expectation is that we cannot go back after the pilot has ended.
Are there any examples nationally where a medical home has assumed full risk?	No. Once you adopt a multi-payer perspective, there is a need to go to the lowest common denominator or a more simple payment system.
Are there any patient incentives?	The self-insured company participants have a separate subcommittee to look at patient engagement. Little has been done.
Are you doing anything to build or retain PCP services or to address areas of dissatisfaction?	This is not a retention program. Our other initiative to increase PCP spending is retention. The learning collaborative is creating great excitement.

6. *Presentation regarding pay-for-performance – Suzanne Felt-Lisk, Ph.D., Mathematica*
    a. Dr. Felt-Lisk provided the following information about pay-for-performance programs.
        - Pay-for-performance is a broad concept that covers any type of incentive (returned withhold, bonus, enhanced payments). The amount at stake must be enough to make a difference, which is generally thought to be 5%. The costs needed to bring about the improvements must be considered when determining payment amounts. Performance may be measured against absolute levels, improvement, or ranks against peers.

- There are currently 258 P4P programs, almost 50% are directed towards hospitals, with 139 sponsors. The programs are claims based, but many now include lab results and pharmacy data so clinical measures are possible. P4P programs are moving to add specialists. In the future, we expect more outcome measures to be used, which will require that there be risk adjustments built into the model.

- Research on the first generation of P4P programs indicates that they are of limited benefit. The study of Massachusetts P4P programs shows that 89% of physician groups have P4P incentive programs. Over half the groups reported that the programs had a moderate to significant impact on the group because the payers generally pointed in the same direction, so that there was enough money at stake to have an impact.

- It appears that Massachusetts has practice characteristics that support P4P programs:
    - There are many large provider organizations.
    - There are complementary synergies for public reporting and network tiering.
    - There are data aggregation structures in place for groups. This results in more credible rates and avoids problems of different payers having different practice findings. There is also energy around EMRs and interoperability.

- When asked, providers disclosed the following views regarding P4P:
    - Providers are generally supportive, but often do not understand program specifics. This has become a bigger issue as the programs get more complex.
    - Since providers have a case-to-case perspective, they are bothered with one case does not fit into the P4P model. They feel that they are being penalized when this variation occurs.
    - Providers worry that P4P does not account for problems with patient adherence to treatment plans. This is a bigger problem for lower-income patients, and leads to the possible problem of non-compliant patients being kicked out of the practice. Possibly P4P programs should pay more when providers are working with difficult groups.
    - Providers have trust issues with claims data.
    - The measurements must be actionable.
    - Providers are frustrated with different payers each having their own measures.

- When implementing a P4P initiative, Dr. Felt-Lisk recommends considering the following:
    - The implementation effectiveness;
    - Obtaining physician input into the selection of the measures;
    - What communication approach can get the physician's attention;

- The importance of providing feedback with the bonus: explaining what was left on the table and why;
- Providing an opportunity for the providers to correct the underlying data, which involves a commitment to a review and correction process, and
- Providing supportive knowledge-based efforts.

- Dr. Felt-Lisk provided the following lessons learned:
  - Match the terms of payment to desired outcomes;
  - Use a broad and balanced set of measures;
  - Anticipate physician reaction and work for a trusting relationship;
  - Remember that the size of the incentive is important;
  - The infrastructure that the physician practices have will influence the effectiveness of the incentives, and
  - Physician engagement is critical.

- Dr. Felt-Lisk offered the following closing thoughts:
- P4P on its own cannot be effective, but it may be used with other initiatives very effectively.
- It is important to remember the consumer/patient and monitor access to assure that there is no inappropriate exclusion of patients.
- Consider parallel rewards. For example, P4P could go very will with the PCMH because both have the same goals.
- It takes time and resources to develop and implement a P4P program. Whether a provider has the necessary resources impacts his or her ability to respond to the incentives. It may take some time to build the needed infrastructure.

b. Commissioners' Questions and Comments:

Questions and Comments	**Speaker's Response**
Physician concerns are the same whether you are paying or not paying them. These concerns relate to the public discussion of provider competence. This is a very difficult problem to address.	I agree.
An enormous variation in measures impacts the provider's ability to move the needle. Alignment of quality measures and a unified multi-payer focus may be a principle to add to our list of principles.	Good comment.
Is there any way to address issues of overuse and misuse of technology?	Some payers are adding efficiency measures. It is very data intensive to identify the problem.
What happens when a provider has patients with co-morbidities?	Most P4P programs are around primary care services and process measures, which

	are needed regardless of the population. NY pays for each category that the patient is in, and in that sense double counts the patient.
P4P is not sufficient alone to outweigh FFS incentives. Blue Cross has combined P4P with global payments that incentivize PCMH attributes.	No comment.
Is there any evidence that one vehicle works better than another?	There is anecdotal evidence that withholds are look upon as severe and not appreciated, but they do get the provider's attention. Size of payment is the biggest factor. There is some evidence that utilizing a group of interrelated incentives (public rating, tiering and P4P) creates a more forceful incentive.
Is there any research that unbundles the impact of the dollars paid and the publicizing of performance information?	Research on the impact of public reporting alone is not encouraging. Both together are best.
The payments help get resources to the providers to enable them to make necessary changes. They must go together.	No comment.

7. *Presentation regarding the intersection between payment model and benefit design – Deborah Chollet, Mathematica*
   Dr. Chollet discussed the intersection between payment models and benefit design, explaining that providers are frustrated when consumer and provider incentives are not aligned. Some payers are aligning incentives through benefit design. Dr. Chollet discussed two types of benefit design strategies: consumer directed health plans (often called "high deductible plans plus spending accounts) and tiered networks.

   These benefit design strategies are variants on evidence-based purchasing. Evidence based information is being developed by AHRQ, which is issuing 5-year contracts to hospital-based organizations to develop evidence based reports around clinical, social science/behavioral health and economics. All are focused on high cost, high volume Medicare/Medicaid services. Kaiser Permanente and Harvard Pilgrim have undertaken managed care initiatives. State initiatives are centering on drug effectiveness, and health care technology.

   a. *Consumer-directed Health Plans*: Consumer-directed Health Plans (CDHP) use high deductibles coupled with personal health spending accounts to increase consumer accountability for health care spending. It may be coupled with consumer information about cost and quality. Implementation has been different from the model:
      - Employers are not fully embracing them and employees do not trust them.
      - There is a risk of under-use of services and obtaining follow-up services.

- Only half of the plans have personal health spending accounts and only half of those employers make a contribution.
- Some focus on consumer information, but most do not. It is not clear how successfully the consumer understands information.
- There have been few plans to evaluation, so it is difficult to know what is happening. When offered as an option, the enrollees who enroll are higher income, and healthier. Most are men. There is also insufficient information regarding cost savings, since the rate of spending increases considerably after the deductible is met. Enrollee satisfaction appears to be lower, possibly because enrollees do not understand the risk they are assuming until they need services. It appears that benefit design impacts actions, but we do not know the best design. We do know that if someone has a health event, they return to a richer plan during open enrollment.

Questions and Comments	Speaker's Response
Are there any programs that limit enrollment in high deductible plans until the personal health spending account has sufficient funds to cover the deductible?	No
Is there any evidence about the severity of illness once the patients with these plans get to the hospital?	No. I think in states with these plans, there is more bad debt in hospitals. In Indiana we saw evidence of insufficient primary care and high hospital bad dept.
Rhode Island has passed legislation requiring payers to assume the responsibility for collecting co-pays and deductibles after the hospital has made a good faith effort to collect.	This approach would address the issue of bad debt, but not the issue of people getting care late.

b. *Tiered Networks*: Tiered networks encourage consumers to choose high quality, cost-effective providers. They assume that consumers make better decisions about health care when they have access to good cost and quality information. To date, tiered network plans hold low market share.
   - There are three conditions for effective tiering:
     - Tiering uses valid and accepted performance measures;
     - Consumers understand the incentives and quality measures, and have access to high-quality providers.
     - Providers receive the information necessary for them to improve performance.

   - The most recent development in tiered network plans is the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs in April 2008. A consumer-purchaser and labor organization coalition developed it. It commits insurers to:
     - Periodic independent review of physician reporting programs

- Abide by standard criteria for physician performance measurement, reporting and tiering programs, and full public disclosure of performance results against minimum standards and national benchmarks.

- The GIC and BCBSMA have tiered network products available. GIC tiers specialists and hospitals. BCBSMA tiers hospitals and PCPs. Tiered products are problematic for physicians who have only a few plan members and get put in the middle tier, which feels punitive. This is an argument for an all-payer approach. Consumers are concerned when they want to move to a lower tiered practice, but the practice is closed or does not take certain types of insurance, such as Medicaid. If payer and patient incentives are not aligned, neither is effective by themselves.

c. Commissioner Questions and Comments:

Questions and Comments	Speaker's Response
To make tiered networks work there must be freedom of choice across plans and providers.	No comment.
There can be different tiering within practices, so the patient does not want to see the covering doctors. This can increase the problems of PCP shortages if not done right.	No comment.
The CDHP model does not work with publicly funded consumers.	No comment.
What is the right model for getting consumers involved? If they do not have skin in the game, it is hard to get them involved.	No comment.
We know that Massachusetts has high health care costs because of the high use of academic settings. Are there benefit designs that guide away form academic centers? Are there other services – lab or radiology – that could be tiered to guide consumers? How do we guide consumers to high value services?	No comment.
How can you guide consumers who do not have much choice to reach high performing providers?	No comment.
You can assure that everyone has access to high performing providers by improving the performance of poorer performers. Medigap also protects the consumer from cost impacts. Maybe we should consider	No comment.

Questions and Comments	Speaker's Response
mandatory co-pays. There is lots of overuse of imaging services. To do this we need standards of care, which identify what we do not want to pay for, what is appropriate care. Currently, plans are not getting to the level of appropriate care, but are using a more broad brush. Congress is debating establishing a comparative effectiveness study organization.	

The meeting ended at 2:00 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 24, 2009

Meeting Date, Time, and Location

Date: Tuesday, February 24, 2009
Time: 2:00 – 3:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors and Support Staff
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane ✓ Dolores Mitchell ✓ Caroline Fisher, attending on behalf of Richard T. Moore ✓ Lynn Nicholas ✓ Melissa Thuma, attending on behalf of Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Harold Miller, President and CEO, Network for Regional Healthcare Improvement and Executive Director, Center for Healthcare Quality and Payment Reform ✓ Glen Hackbarth, Chair of Medicare Payment Advisory Commission	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC ✓ Seena Carrington, MA DHCFP

Meeting Minutes

Co-Chair Leslie Kirwan introduced Caroline Fisher, attending on behalf of Senator Moore, and Melissa Thuma, attending on behalf of Representative Stanley. Ms. Kirwan explained that this is the third in a series of educational meetings, which will focus on episode-of-care reimbursement and evidence-based purchasing. Harold Miller will be participating in person and Glenn Hackbarth will be joining the Commission via phone.

Co-Chair Sarah Iselin reminded the attendees that the March 13 meeting will run from 11am to 2pm and to bring lunch. That meeting will focus on global payment and global budgeting. Ann Robinow from Minnesota, founder of Patient's Choice, and a representative from BCBSMA will be presenting case studies on global payment. Materials will be sent out in advance, including a whitepaper on global payment and one on the non-payment models mandated in the statute (e.g., tiering benefits, evidence-based coverage).

Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 24, 2009

1. *Report on Stakeholder Meetings – Michael Bailit, Bailit Health Purchasing*
    a. Michael Bailit reported that since the last Commission meeting he has met with 12 employers and employer representatives to discuss the Commission's list of principles. The two key messages from the employers are:
        - The objective of cost containment needs to be explicitly stated in the principles, and
        - The role of the employers needs to be incorporated into the Principles.

    b. Michael will be incorporating the employers' ideas, as well as ideas from the other stakeholders and circulating the revised Statement of Principles to the Commissioners. He noted that the principles have gotten longer with the stakeholder input, and asked the Commissioners to carefully review the list to determine if they are too long. He expects to distribute the revised principles on Wednesday to the Commissioners.

    c. Commissioners' Questions and Comments

Question and Comments	Speaker's Response
What did the employers mean by asking that cost containment be more explicit in the principles?	The principles need to clearly state that payment reform is a goal of cost containment.
As the principles have expanded, are they internally inconsistent? If so, is more time needed to resolve these inconsistencies?	There are internal tensions, but they were there before the principles went out to the stakeholders.

2. *Overview of episode-based payment models – Harold Miller*
    a. Mr. Miller provided a conceptual framework for considering episode-based payment models. The health care cost equation considers the
        - number of conditions per person,
        - number of episodes of care per condition,
        - types of services provided per episode of care,
        - number of processes per service and
        - cost per process.

    b. Currently fee for service (FFS) captures only 2 of the cost variables: the number of processes provided and the cost of the processes. There are no limits on the number of services offered. Under FFS some services are not reimbursed and not all processes are provided for each patient.

    Payers have added utilization review and pay-for-performance to make sure all appropriate processes are done for each patient.

    Under the other extreme, which is traditional capitation, everything is covered under a fixed price. The problem with this approach is that the provider is at risk for treating sicker patients (the insurance risk) as well as

for what services are provided (performance risk). The provider is assuming both the insurance risk and the performance risk.

c. Episode-of-care payment models pay based on episodes. Under this model, offering too many services is not a problem and providers have the flexibility to decide what services to provide. Outcome monitoring provides incentives for providers to provide the right services. There are still no limits on the number of episodes. The response is to offer a condition-adjusted capitation or risk adjusted global fee.

d. Episode-based payment systems are applicable to different kinds of conditions:
   - minor acute conditions, the episode of which is based on the resolution of the minor acute condition;
   - major acute conditions, the episode of which is based around the resolution of the major acute condition or a typical window of time, and
   - chronic conditions, the episode of which is based on resolution of the exacerbation of the chronic condition symptoms or an arbitrary period of time.

e. Episodes have two dimensions:
   - length of time to cover a condition and
   - providers and services to be included.

f. An example of the components of a major acute episode is as follows:
   - Length of time: pre-admission, hospitalization, post-acute care and readmissions within a specified time post discharge, and
   - Providers: physicians, devices and equipment, drugs, non-MD staff and facility costs.

g. There are five possible stages to transition to a comprehensive episode-of-care payment system:
   - Create a case rate for each provider in each phase of an episode of care (e.g., pay each physician a single fee for a patient's hospital stay).
   - Include a warranty in each provider's case rate (e.g., include the cost of any related hospital readmission in the hospital's DRG payment).
   - Bundle case rates for all providers in a particular phase of an episode of care (e.g., pay a single fee to both the hospital and physicians managing the hospital stay).
   - Bundle rates with warranties (e.g., pay a single fee to the hospital and physicians, covering the initial admission and readmissions.)
   - Combine the case rates for all phases of an episode (e.g., pay a single fee for both inpatient and post-acute care)

- CMS is bundling hospital costs and surgeon fees for case rates in pilots.

h. Severity adjustment is essential to episode-based payments. FFS implicitly adjusts for patient severity. There are two types of adjustments – ones based on clinical categories, and ones that are regression based. There is a debate as to which is better.
    - Using episode-of-care payments for chronic conditions has specific challenges. A hospitalization for a chronic disease exacerbation could be treated as an episode, and paid for in the same way as a hospitalization for an isolated acute episode. However, because hospitalization can be prevented, it makes more sense to think of a chronic condition episode as a fixed period of time. Think of the hospitalization as an avoidable service during that period of time.
    - Setting the price of an episode of care can be done by regulation (i.e. Medicare), negotiation (i.e. commercial insurers), or competition. There is no mechanism to steer the patient to the lower cost provider. Moreover, the consumer's share of the cost is the same regardless of provider selected or actual cost. The alternative is to have the consumer pay the last dollar of the price, rather than the first dollar. The problem is that patients do not know the price differential going in. Some websites are being developed. See Carol.com.
    - Do episode of care payment systems need to be implemented on an all or nothing basis? When using episode payments to achieve specific goals, you need to consider the goals to decide on what type of episode-based payment is best. If the goal is to:
        - give providers flexibility to decide what services to offer beyond FFS codes, then pay a provider a fixed amount during his/her portion of an episode.
        - control over utilization of services and/or providers within an episode, then pay a fixed rate for all services controlled by a provider,
        - coordinate provider decisions about care, then bundle payments for the providers together.
        - facilitate consumer choice of lower-cost providers/services, then define a single price for an entire episode and differentiate co-insurance amounts.
    - If you want to use other approaches to achieving the goals, there are other payment approaches that can be used. If the goal is to:
        - give providers flexibility to decide what services to offer beyond FFS codes, then authorize additional FFS codes or an "all other" fee (e.g., care management fee).
        - control over-utilization of services and/or providers within an episode, then use P4P incentives based on retrospective episode profiling.
        - coordinate provider decisions about care, then facilitate gain-sharing arrangements.

  - facilitate consumer choice of lower-cost providers/services, then use retrospective episode profiling of providers plus differential co-insurance amounts.
- Other models can also be integrated. Pick areas where the goals need to be met and apply an appropriate model. For example if the goal is provider flexibility, consider the medical home. If the goal is consumer choice, certain types of surgeries lend themselves to consumer price comparisons.
- If episodes-of-care payments are to be implemented on a partial basis, you need clinically distinct conditions. When dealing with a condition with co-morbidities, it can become complicated. Should the episode condition be diabetes, COPD, or diabetes plus COPD? Is a global fee better for conditions with co-morbidities? No one knows the answer because no one has done this yet.
- It is possible to combine capitation with episode payments. There could be a global fee for a particular condition with the outpatient care based on a medical home model and any hospitalizations paid on an episode basis.
- Other implementation issues relate to who gets the episode payment and are new billing and payment systems needed. If the providers are an integrated system, the system can accept payment and divide it internally. Joint ventures, such as PHOs, can be formed to accept and divide payments. The payer could pay each provider directly according to pre-determined rules, a form of 'virtual bundling." It is possible to base episode payment on existing FFS billing systems. These systems can adjust fee levels or pay bonuses to reconcile total billings against prospectively defined payments. There may be a need for new fee codes for currently unpaid services.
- Since episode-based payments provide incentives to provide fewer services or poorer quality care to a patient, there must be public reporting on quality of care measures. The system must also ensure that bad outcomes are included in the episode and add pay-for-performance quality incentives for things not captured in the episode.
- Successful implementation requires that all payers are involved. There is a need to think about improved payment systems and restructured delivery systems simultaneously.
- Episode payments have been tried several places and they have worked:
  - In 1987, an orthopedic surgeon in Lansing, Michigan worked out a fixed total price for surgical services for shoulder and knee problems. A study found that the payer paid 40% less than it would otherwise, and the surgeon received over 80% more than otherwise.
  - In 1991 CMS did a demonstration project for heart bypass surgery. Each of four hospitals received a single payment covering both Part A and Part B services for CABG, with no outlier payments permitted. Hospital and physicians were free

to split the combined payment. The results indicated that physicians identified ways to reduce length of stay and unnecessary hospital costs; costs decreased between 2% to 23%; post-discharge outpatient expenses decreased and patients preferred the single co-pay.

- Currently there are a few episode-of-care initiatives:
  - There is a Medicare acute care episode demonstration in which CMS will pay a single amount to cover both hospital and physician services for cardiac and orthopedic surgeries.
  - Geisinger offers a warranty that covers any follow-up care needed for avoidable complications. Geisinger is an integrated system and the only plan paying on this basis is the Geisinger Health plan.
  - Prometheus Payment covers full episodes of care and all providers associated with the episode. It uses a combination of historical costs and evidence-based information to set payment levels. Prometheus estimates that overall 53% of costs are associated with potentially avoidable complications. More money could be saved in treating CHF, diabetes and COPD, than in treating conditions, such as hip and knee replacements, that require surgeries.
  - Minnesota is phasing in episode-based payment, which it calls "baskets of care". The state is currently defining baskets of care for episodic payments. By 2010 providers may voluntarily establish package prices for the baskets of care. Providers must accept the same fee from all payers.

i. Mr. Miller offered the following concluding thoughts:
- Think about the types of episodes with a large volume of cases and potentially large savings;
- Develop common definitions of episodes;
- Use a severity adjustment;
- Start reporting on the basis of episodes, but continue to pay FFS. The reporting must be public.
- Provide technical assistance to providers to reduce costs;
- Implement software enhancements that can distinguish which claims are to be paid on a episode basis and which not, and
- All payers need to agree to pay in this manner for the episodes identified.

j. Commissioners' Questions and Comments:

Question and Comments	**Speaker's Response**
Can costs associated with end of life care be handled as an episode? Hospitals see this as an area where there is a great deal of	I think you can, but not much work has been done on this issue. You can think of the chronic condition population and factor

Question and Comments	Speaker's Response
futile care being provided.	in end of life costs, or you can think of end of life as a separate episode and how to manage it. The CMS hospice care uses time to demark end-of-life. You must get physicians willing to tell people that they are going to die. Currently there is no incentive not to give the last round of chemotherapy.
You identified three types of episodes (minor acute, major acute, and chronic). Where do most of the dollars fall for people under age 65?	They fall between major acute and chronic conditions. There are lots of labor and delivery costs in that age group.
Where would behavioral health costs fall?	The question is whether it is co-morbid or a single diagnosis. In Pennsylvania we looked at readmissions data, and depression was one of the top 4 diagnoses. Prometheus has found the top diagnoses to be CHF, CODP, diabetes and depression in the under 65 commercial databases.
When considering who get the payments, what is the breakdown of dollars?	It depends on the geographic area. If you are talking about major acute episode, it varies dramatically across the country. In some areas physicians and hospitals are at odds, in other areas PHOs work well together. Maybe it makes sense to start with someone who will take the dollars and let others see that it works.
We are gathering some baseline data around where dollars are spent and organizational structures.	When thinking about readmissions, ask who is responsible. If it is for an acute episode, the readmission is probably driven by how the hospital did or did not manage the transition. For chronic conditions, readmissions are probably based on something going wrong in the community.
We need to do some homework around inventorying relationships between hospitals and providers and asking is it a real PHO with collaboration.	
Is there any experience with partial implementation and monitoring of total costs? Are cost savings sustainable across the entire system?	There have not been enough studies done to give a definitive answer. In the 1990s CMS did a demonstration around cardiac surgery, which only bundled hospital and physician costs. CMS did not see any costs being pushed to post-hospitalization services to make more money. This is only one study, involving only acute episodes of

Question and Comments	Speaker's Response
	care. The real risk is with chronic conditions.
When one is combining global fees and episodes of care, it opens a gap that could result in more payments. You never mention health plans until the end of your presentation. Our task will be to talk with lawyers regarding how to do this and avoid anti-trust issues.	There is a legal exemption where the state is involved. Minnesota came up with a system, asked for comments from payers, and then each payer individually could accept or not.
With a condition-adjusted capitation, there is no incentive to control the volume of care. This is compounded by the differences between acute and chronic care. There are different incentives if back pain is treated as an acute or a chronic condition.	Go back to the goals. If the problem is over utilization of back surgery, episode-based payments for back surgery are no solution. If you think the need is to have hospitals and physicians work together to get cheaper back surgeries, then an episode payment involving both hospital and provider services will work. The problem is if the cost of the surgeries declines, how to you get the savings back to the employers paying for the coverage. If you are treating back pain as a chronic condition, then move bundling to earlier in the process to control use of back surgery and use of MRI. You could do a partial model with the physician responsible for 10% of the cost of hospitalizations.
Where is Minnesota in implementing their episode of care system?	I suggest that you go on the Minnesota Department of Health website. I think they will focus on major acute episodes because some providers already want to do this and compete on prices. Minnesota has lots of history of patients choosing providers based on price.
Why would physicians want to compete on price?	Consumers will switch when prices are different. Providers will find a way to lower costs. The problem will be lack of patient volume to get providers to respond. The BHCAG (Buyers Healthcare Action Group) system included both an episode payment and a global fee structure. The Minnesota legislature passed only the episode piece, but not the global fee structure.
Minnesota is hugely integrated with few stand-alone hospitals and almost no solo physician practices. This is a very different	

Question and Comments	Speaker's Response
structure from Massachusetts.	
We tried very hard to get Patient Choice adopted in Massachusetts and no one would go for it. (NOTE: Patient Choice was a program developed by the Minnesota BHCAG which featured global and episode payments for providers and patients choice of providers based on cost of services.)	
Physicians are concerned about the relative weight of payment for services.	You are raising two separate issues. Under a severity adjustment, you must assure that you have properly adjusted for different patients. The other issue is whether the episode is priced properly. Medicare says this is what you will be paid. The question is how to set prices. You can't compete on price for rate services using a market-based system.

3. *Case Study of Episode-Based Payment – Glenn Hackbarth*
    a. Mr. Hackbarth opened his presentation with statements of congratulations to Massachusetts for implementing its universal health care initiative. He expressed the sentiment that people in Washington, DC want Massachusetts to succeed. He encouraged the Commonwealth to develop new payment systems and seek a Medicare waiver to support the effort, but warned that additional funds are not likely to be available.

    b. Mr. Hackbarth offered the following observations about episode-of-payment models:
        - Episode-based payments offer a possible benefit, but are not the sole solution.
        - Hospital-based episode-based payments are an easier target than ambulatory episodes. Ambulatory payments are important, but more complex and challenging, than paying episodes around a hospital admission. Med PAC does not pretend to know how to do hospital-based episode payments. We are recommending that CMS start with a pilot project to work thought the operational issues.
        - Med PAC's responsibility is conceptual and directional. The operational responsibilities are with CMS, which has staff and technical capabilities to engage with health care providers to design and implement a new system of payments.
        - You need to advance in stages. First pilot different forms of payment. Once you get to a preferred form, then you need to disclose to hospitals how they are doing with defined episodes and associated costs. Hospitals have not focused on episodes of care. Physicians may not know readmission rates for COPD, for example.
        - Focus on episodes that have large volume.

- The state of readiness of providers to accept episode payments will vary based on their ability to coordinate, share and allocate resources. Medicare payments have not encouraged this type of collaboration; rather Medicare has encouraged maximizing income within ones own silo. We need to change focus, but that won't be easy. Hospitals see physicians as almost unmanageable, and physicians view hospitals as unresponsive and too powerful. Past efforts to breakdown barriers have not been that successful. The inertia in the system is considerable.
- Implementation of a new payment system must be on a voluntary basis.
- In considering what to do with those who do not volunteer, you cannot leave the status quo so comfortable that they won't change. For those who do not volunteer, you need to exert pressure/discomfort to incent change of the old ways. This could be in the form of a penalty for excess hospital readmissions. It could be a carrot approach with Medicare gain-sharing with hospitals and providers. It is currently difficult for hospitals and physicians to share rewards. Gain-sharing could only be under certain conditions to protect against abuse and to create conditions for constructive dialog between physicians and hospitals.
- One of the basic rules for obtaining a Medicare waiver is that it is budget neutral for the Federal government. Determining budget neutrality is both an art and political. With the retirement of baby boomers and the current economic crisis, there is an increase in federal obligations, which is unsustainable. The environment in which Massachusetts seeks a waiver may be more demanding than in the past.

c. Mr. Hackbarth identified additional changes that must be done simultaneously to bring about needed change:
    - Significantly change the payment system to increase payments for PCP services. This is very important in the management of chronic illness and is easier to do than episode-based payments.
    - Immediately begin feeding back to physicians and hospitals information on episodes-of-care by comparing patterns of practice with peers.
    - Medicare is investigating the idea of paying on the basis of Accountable Care Organizations. (Eliot Fisher has written on this topic. See the current edition of *Health Affairs*.) CMS would continue to pay providers on a FFS basis, but create opportunities for organizations to share in savings. Performance would be measured on total cost of care (ambulatory, acute and chronic), including all types of providers. Patients would have a free choice of providers. Whether this can be operationalized is still open to question.

d. Commissioner Questions and Comments:

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Question and Comments	Speaker's Response
What is CMS' timeline for moving to episode-based payments and deciding whether it moves beyond a volunteer basis?	I could imagine moving beyond a voluntary basis once we have worked out the bugs and some provider organizations have had success. Other providers need to say "I want some of that and I have a template for how to do this." The timeline to move to a broad based implementation is a function of political acceptance, which requires legislative change. The other big barrier is operational and CMS' capabilities. CMS is much maligned and has an impossible job because they are asked to do complicated things with too few resources. Congress could accelerate the adoption by increasing investment in CMS operational capabilities, but it has not been willing to do so. I am hesitant to give a timeline. It will take a number of years (3 to 5 years) to implement episode-based payments on a wide-scale, voluntary basis.
There are other types of incentives to encourage provider organizations to create more integrated systems, such as leaving the Sustainable Growth Rate (SGR) system in place. NOTE: SGR is a mechanism created by Congress in the 1900s that currently is applying pressure on Medicare physician fees. When the growth in physician services is greater than GDP, rates need to decline. Congress has moderated the impact of SGR annually. To meet SGR targets next year, rates would need to be cut 21%, which Congress won't let happen.	There are other incentives besides SGR. If you want to change the payment system and need the active participation of providers, you need to make the status quo uncomfortable. Some people think SGR can be the pressure to change payment methodologies, particularly in the context of Accountable Care Organizations (ACOs). For physicians and hospitals wanting to be ACOs, the incentive is an alternative payment system, which lets physicians get out from under SGR.
With hospital margins low, there is an increasing appetite to do something new and better. Is there an opportunity for CMS to work with providers on a statewide basis to do a demonstration in which we can find incentives that will encourage everyone to join?	In the last several years' hospitals have had high margins across all payers, and this did not lead to daring innovation. The evidence seems to be to remain comfortable, not change. More dollars do not lead to more innovation. Any reward for innovation must be targeted and precise.
The big inequities in payments to hospitals are on the private side, so it is hard for all hospitals to have enough funds to innovate. We need to think about leveling the playing	The other debate in Washington is about universal coverage. To the extent that Washington spends more money, it will be for universal coverage. The quid pro quo

Question and Comments	Speaker's Response
field in terms of commercial payers. Don't pay one hospital more than another because of market clout.	for providers is to reduce the burdens of uncompensated care through universal coverage. In terms of payment policy, we will demand more of providers, not less.
On one of your slides you say, "CMS cannot designate efficient providers." Transparency does not prohibit patients from going to inefficient providers. Is there any change in the gag law not to release data?	Release of information will not conflict with the freedom of choice provision in the Medicare law. What would violate the law is if CMS tries to limit choice to certain groups of providers. Even a PPO would require legislation. Then the question is political and it is very difficult to get people to embrace this concept because it prompts constituent reactions to protect their local provider from being excluded for a Medicare network. With regard to the litigation in which CMS was found to not have the authority to release CMS data to a private organization, Med PAC will be making a recommendation to Congress to allow the release of the data.
In the previous presentation Mr. Miller contrasted episodes to risk-adjusted capitation. Are there other more effective models?	Disease-based ambulatory payment is appealing. The problem is the lack of organizational infrastructure to receive global payments. Some organizations, such as Harvard Vanguard, are available, but they are the exception, not the norm.
BCBSMA is seeing increased interest of hospitals, and other providers in joining PHOs to experiment because they see this is the future of reform. In the last 6 to 9 months, we have seen higher enthusiasm to accept alternative payment models. I am encouraged in seeing providers more open to different types of payments.	In terms of the dynamics of payment reform, ideally we are doing complementary things. Ambulatory episodes may be more viable in different markets. There may be a ripe opportunity for private health plans to go after this type of change, rather than Medicare. Medicare Advantage is its way to allow different opportunities to try different payment models. The problem is that the benchmarks are set in a way to undermine Medicare Advantage as a tool for innovation.
At least we know from Medicare Advantage that when CMS pays capitation to a specific organization, consumers will accept restricted choice. Even then, you need a large geographic area to figure out capitation. It is hard to set the capitation rate: if it is too low, plans drop out; if it is	

Question and Comments	Speaker's Response
too high, there are no cost savings.	

4. *Overview of Evidence-Based Purchasing – Michael Bailit*
    a. Mr. Bailit reminded the Commission that evidence-based purchasing is not a payment model, but it is part of the Commission's mandate. It can work in support of a payment model to reduce costs for unnecessary or less valuable services. The Commission will have background papers available on several non-payment models in the future.

    b. Mr. Bailit presented the following information on evidence-based purchasing (EVP):

- The context for EVP is that experts estimate that between 25% and 50% of health care expenditures produce no patient benefit and can create harm. Researchers have shown that in Medicare there is an inverse relationship between health care spending and health care quality.
- EVP uses research evidence to decide what to cover. Currently the issue is the degree to which evidence is being used to make coverage decisions. Currently its application is not sufficient to limit waste.
- Barriers to using evidence to make coverage decisions are:
    - FFS financial incentives;
    - Supply-induced demand
    - Patient advocacy
    - Professional mission
    - Lack of information about what works and if it works, is it more effective than something else.
- Effectiveness research is being done in the US by AHRQ-supported practice centers, by state initiatives including Medicaid initiatives, and by health care technology assessment vendors. The 2009 Economic Stimulus Package includes $1.1 billion in federal funding to investigate how different treatments compare in effectiveness. However, lobbyists pressed to include language in the bill's conference report saying Congress doesn't intent for Medicare or other "public or private payers" to use the research to make coverage decisions.
- Other countries have done more in this area than the US. The National Institute for Health and Clinical Effective evaluates the cost and effectiveness of treatments and guides coverage policy for England's National Health Service. Similar organizations exist in France, Denmark and Germany. The UK's Cochrane Collaboration is a private effort that serves a similar function but does not advise the government.
- Evidence of effectiveness can be applied in five different ways:
    - Exclude coverage of services of no value;

- Exclude coverage of services of low priority/low value (Oregon uses this approach);
- Limit coverage of service to only those clinical applications were evidence of effectiveness exists;
- Limit coverage to services that produce the highest value when considering both clinical effectiveness and cost (Medicare is prohibited from doing this, but it is often done in establishing commercial insurers' drug formularies.)
- Limit coverage of services so that higher value options are attempted before lower value options are covered (stepped approach).

- Evidence is also used in Value-based Insurance (Benefit) Design by varying the cost sharing to provide incentives for patients to use a) high value services and/or b) providers with demonstrated superior effectiveness.
- Washington state's Medicaid program has created a grading system for evidence of effectiveness:
  - A = evidence is based on randomized controlled clinical trials
  - B = evidence is based on consistent and well-done observational studies
  - C = evidence is based on inconsistent studies
  - D = studies show no evidence of effectiveness, raise safety concerns, or document no support by expert opinion.
- Washington generally approves A and B services for coverage. C and D services are approved only upon special case-specific review.
- Washington reduced spending for bariatric surgery from $970,000 in 2003 to $56,000 in 2006; realized a $10 million saving in enteral nutrition spending, and reduced ADD drug spending for children through required second opinions and realized a 3:1 return on investment.

c. Mr. Bailit offered the following concluding thoughts:
   - Evidence is not used in purchasing to the extent that it could. For example, Wellpoint, a large national insurer, has only 20 FTEs involved in this activity.
   - There are real challenges to the application of evidence.
   - EBP can serve to complement payment reform. It would require statewide, all payer participation.

d. Commissioner Questions and Comments:

Question and Comments	Speaker's Response
EOHHS has been challenged with looking at studying the ability to establish a regional comparative effectiveness organization.	

Question and Comments	Speaker's Response
If the federal government is setting up one and sending out dollars regionally, I don't know why Massachusetts would want one too.	
This issue on the federal level provokes fear and lobbying. I recommend that those in the state look at just starting with 3 or 4 high cost interventions were evidence of benefit is questionable and where practice varies widely. There is a local evidence-based organization here in Boston. If physicians could be comfortable using this in certain areas, it would make it easier in the future.	Washington state started with services that showed patient harm.
Everyone would benefit from evidence-based service information. If we could get this rolling, it could be a big help.	
If we could find 4 or 5 areas, there is a benefit of starting on a small scale with uniformity. We could manage consumer response and protect each plan's competitive advantage.	
Hospitals are doing things because hospitals down the street are doing them. Maybe we need to do something with what we already have, rather than studying this.	
It would be interesting to know who is funding consumers who are complaining; often it is the manufacturer of the equipment being evaluated. Maybe we need disclosure of who is funding the advocates.	

e. *Leslie Kirwan closed the meeting by summarizing the hurdles to implementing episode-based payments:*
   - Institutional readiness;
   - Definition of episode;
   - Gaps and how to handle them so costs do not appear somewhere else;
   - Role of the consumer and how to enhance that role;
   - The spectrum of voluntarily implementing the payments: looking at carrots and sticks compared to how long it will take to get this done, and
   - For those who cannot move to innovation, what is the default position?

f. Sarah Iselin added that during the Commission's 6th meeting (the one after next), the Commission will be looking at what is its vision and how do we get there. The Commission will wrestle with the issues its members started to discuss today.

The meeting ended at 4:45 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
March 13, 2009

Meeting Date, Time, and Location

Date: Friday, March 13, 2009
Time: 11:00 a.m. – 2:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane (by telephone) ✓ Dolores Mitchell ✓ Richard T. Moore ✓ Lynn Nicholas ✓ Melissa Thuma, attending on behalf of Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Deborah Chollet, Mathematica Policy Research, Inc. ✓ Ann Robinow, presenting on the Patient Choice Health Care Payment Model in Minnesota ✓ Patrick Gilligan, Senior VP, BCBSMA ✓ Dana Safran, Senior VP, BCBSMA	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Deborah Chollet, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC

Meeting Minutes

Co-Chair Leslie Kirwan introduced Melissa Thuma, attending on behalf of Representative Stanley, and noted that Nancy Kane was joining by telephone. Ms. Kirwan explained that she recently spent a week in the hospital. During her stay, she gained a different perspective on the health care system and its related needs. She also reported that as chair of the Commonwealth Connector Board she is pleased to report that premium costs will be decreasing for the average member of Commonwealth Care. She sees this as a victory for both the Commonwealth and for all enrollees. It is an important step in sustainability. She does not want this fact to be overshadowed by some politics around the Connector accepting a new Commonwealth Care vendor.

Co-Chair Sarah Iselin reminded the Commission members that this is the last of the learning meetings. The topics for today's meeting will be global budgets and global payments. Deborah Chollet will be providing an overview and she will be followed by two case studies: BCBSMA's Alternative Quality Contract and Minnesota's Patient Choice Program. She also explained that the Commission would be reconvening in a few weeks to begin the process of developing recommendations.

1. *Revised Principles – Michael Bailit*
    a. Michael Bailit reported that since the last Commission meeting he distributed a set of revised principles and received feedback from half of the Commission

members. The set of principles he is distributing at this meeting incorporates most of the feedback he has received, and reflects a comprehensive discussion. He explained that as a result the principles are longer, about which several Commissioners expressed regret. He noted that the principles would now serve as a tool to evaluate payment models. He explained that there are three rounds of stakeholder meetings as part of this process. He will be holding the second round next week during which he will be explicitly requesting recommendations regarding payment strategies. He will be sharing the results of his meetings at the April 3rd Commission meeting.

2. *Overview of Global Payments – Deborah Chollet*
    a. Global payments are payments bundled at the patient level and include all services over a time period, usually a year. Payment covers all services required by the patient over the contract period or for a set of covered services. The key to understanding global payments is the extent to which providers are put at risk. They are put at risk for the occurrence of services needed, for the amount of services provided and for the cost of services provided. Providers are incented to provide services efficiently. There are no incentives to over provide care or to raise rates. Therefore, the source of risk is the occurrence of services needed. Plans have developed ways to limit provider risk, often in response to state regulators.

    b. The intended provider incentives are to:
        - Contain costs by reducing use of unnecessary services.
        - Encourage efficient integration and coordination of health care services.
        - Potentially improve quality via coordination of care.
        - Because providers get reimbursed a flat amount, there are some inherent incentives to integrate care efficiently. History has shown that without that type of integration, it is difficult to control costs. Providers can be induced to respond efficiently with an overlay of direct quality incentives, such as pay-for-performance.
        - Global payments may also incent providers to avoid predictably high-cost patients. If the provider has a high-cost patient, the provider won't make the necessary margin. There is no evidence that providers actually avoid these high-cost patients.
        - Global payments also provide incentives for providers to consolidate into larger organizations to offset the impact of an unusually high-cost patient.

    c. Evidence regarding the impact of global payment on health care is inconclusive, since most studies, which occurred in the 1980s and 1990s, were disjointed, opportunistic, used different research methods, and did not corroborate one another. No researcher found any huge negative impact, but long-term impacts are not known. There is anecdotal evidence that provider organizations could not integrate services across settings sufficiently to control costs. In the early 1990s, the National Association of Insurance Commissioners (NAIC) developed an advisory that if providers were the primary risk holders, they needed reserves and to respond to the rules of the state insurance regulators. This generated

considerable controversy. California has the most comprehensive legislation, requiring providers to disclose their financial condition to insurers and to the Insurance Commissioners. Carriers can hold reserves for providers to allow them to bear risk under a global capitation.

d. Carriers have developed several ways to reduce provider risk, including:
   - Risk adjusted payments, in which the payment rate is varied for patient characteristics. There would be higher payments for older patients, and patients with known diagnoses. This addresses issues of patient dumping and the under-reserve issue.
   - Blended capitation, which allows for local variation in cost and provider practices. Under this methodology, the state would set capitation and allow for different rates for different geographies. It gives systems a place to start.

e. Once the risk has occurred, insurers use the following approaches to limit risk:
   - Stop loss shifts the risk back to the carriers when costs exceed a certain level. This can be set either at the patient level or the total practice level. This approach has certain efficiencies in that once the patient costs are over the attachment point, there are a need for review by the carrier.
   - Reinsurance reduces provider loss, but providers usually retain a percentage of total costs.
   - Partial capitation, which is a global payment only for more predictable services such as primary care. The provider remains at risk for service need and cost of care.
   - Risk corridors limit providers' upside and downside risk. Under this system the carrier assumes liability for high-risk costs, but also gets the benefit if costs are low. CMS uses risk corridors in Medicare Advantage contracts.

f. Methods of limiting provider risk are complex to develop and update. They must be updated constantly and need lots of data. Incentives to maintain and improve quality and efficiency are also complex to develop and administer. Embedded in blended capitation rates are cost and practice targets. Quality incentives are indirect. It is possible to have a blended capitation to reduce disparity, but a quality incentive is usually overlaid.

g. Commissioners' Questions and Comments:

Question and Comments	Speaker's Response
Are there studies showing that providers receiving a global payment do not avoid the high-cost patients.	None of the research looking at this question has found any evidence of high-cost patient avoidance or dumping. Most patients have employer-based contracts which provide little opportunity to dump.
The issue for individuals without employer coverage is obtaining access to care.	If the coverage is individually based, dumping may be a problem.

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Question and Comments	Speaker's Response
Under a blended capitation are there any prioritizations based on specialties?	None that I know of.
In the past global capitations have resulted in a continuous ratcheting down of payments as savings come out of the system to the point that there are no incentives for providers to participate. Does there get to be a point of equilibrium?	This end game has not emerged in California. My speculation is that this is because Kaiser establishes a price level around which other providers compete. This staff model competes on the basis of quality, so there is some quality competition also. When independent physician practices are trying to coordinate care, it does not work as well, so there is more incentive to ratchet down rates because price becomes the only currency for competing.
Given the limits of research, how successful is primary-care-only capitation or some mix that is less than a global cap.	Probably the largest capitation systems are state Medicaid programs. Most have a partial cap for primary care for mothers and children. Most think that it works, but I am not aware of any evaluation assessing where do you draw the line (as to what is included under the cap). States have used capitation for a relatively healthy population, but have consistently carved out mental health. For a more diverse population and for more people, it is untested where you would draw the line. There are renegotiations every year as the world changes and providers become more sophisticated.
In a way medical home variations are essentially suggesting a partial cap. When there is no risk for those receiving a capitation payment, you may have services and dollars going out of the capitation. How you create balance is complex and critical.	Michael Bailit: Most medical homes are built on fee for service. Deborah: global payments are satisfactory for those used to accepting risk. When applied to small group practices, it is more difficult. You need a multi-specialty practice with strong control of the hospital.
In California the average number of physicians in a practice is in the 300s; three-quarter of practices are over 50. It is a very different than how Massachusetts is structured.	California is a mature system. The consolidation happened as the system grew up with global payments. Global payments force providers to join into multi-disciplinary systems. The less there is of global caps, the less are the incentives to combine.
There is also a different culture in California. Kaiser has been there so long that they set the benchmark. There are	

Question and Comments	Speaker's Response
different patient expectations here. Outside of Rt.128, the largest group is 15 to 20 members. We don't have large groups able to accept a global capitation.	
More than half of our payments go to seven groups in Massachusetts. There is a lot more consolidation than some people think. Some of the early pioneers are modest sized groups in Western Massachusetts. I caution the group about jumping to conclusions about California from a decade ago. "Global capitation encourages accountability regarding quality and efficiency" is as much the message "as global capitation puts providers at risk."	
We are working on a homework assignment around what the Massachusetts system looks like: MD groups by size, payment volume by type of reimbursement, highest prevalent procedures and conditions, and hospital affiliations.	
Is it possible to have a trend line regarding practice size.	

3. BCBSMA Case Study – Patrick Gilligan and Dana Gelb Safran

Andrew Dreyfus framed the initiative by explaining that three years ago BCBSMA launched a 10-year initiative to transform health care in MA with the goal of everyone having safe, effective care. BCBSMA also is promoting HIT with its participation in the e-prescribing collaborative. They also have an initiative with the Massachusetts Hospital Association to educate hospital trustees about quality. BCBSMA is also working with a collaborative regarding quality measures, and supports five pioneering practices to accelerate transformation. These efforts are being undertaken in response to demands from employers to cut costs and improve quality and from providers and hospitals that are saying that fee-for-service does not work because it is an open invitation to health plans to manage costs and quality of care. Providers recognize that they need to be better regarding efficiency and quality.

The result of these efforts is a new contract. A year ago there was skepticism in the provider community about assuming more risk under this contract. In the last six months there has been increased enthusiasm because providers see a blended payment methodology as the future. Those that can accept this risk now will be more successful in the future. BCBSMA recognizes blended capitation as an answer, rather than the answer.

a. Patrick Gilligan, Senior Vice President, Health Care Services explained the key components of the new payment model as follows. The Alternative Quality

Contract model is composed of key components that are standard across provider entities:

- Integration across the continuum of care.
- Accountability for performance measures (ambulatory and inpatient).
- Global payment for all medical services (health status adjusted).
- Sustained partnerships through execution of a 5-year contract.

The contract elements reward and support integration. Ideally, BCBSMA wants the PCP, specialists and hospital to accept the risk. Sometimes only a multi-specialty group without the hospital will be the risk-bearing entity. There is a group in Western Massachusetts with 46 physicians and no hospital that is doing very well under this arrangement. The model can accommodate global payment by making monthly cash payments, which the entity distributes, or it can pay FFS in the interim with a year-end settlement. The five-year contract with budgets set in advance makes a huge difference because time is not spent on continually negotiating. The contract will eventually cover all BCBSMA product offerings.

The model works by setting budgets for a five-year period of time. The starting budget is based on historical costs. In the 1990s the budgets were starved and started too low. BCBSMA is working to set budgets correctly. The model recognizes inflation by using CPI, and not historical medical inflation. BCBSMA believes that there are enough dollars in the system. BCBSMA is trying to reduce the rate of increase over five years. There is also a significant upside bonus on quality measures. BCBSMA holds providers accountable for cost and quality with quality-based incentives up to 10% of the overall budget. The global capitation is adjusted annually for changes in health status of the covered population. It is diagnoses based, not procedure based, which BCBSMA thinks is a reasonable way to address the sick patient problem.

BCBSMA is willing to share risk, if the providers are not ready to accept full risk. BCBSMA wants providers to take total capitation, but recognizes that providers might have different infrastructure costs. They can use the budget to pay these costs. The budget also needs to cover the costs of risk management. If an entity wants stop loss, BCBSMA can provide it for a cost or they may go onto the open market. Blue Cross can also provide total aggregate risk, so that if the provider wants this protection, they can purchase it. This payment model differs from capitation in the following ways:

- There is a significant upside potential based on a sophisticated set of measures that address patient safety, appropriateness of care and patient satisfaction. This is the biggest difference.
- The initial payment level is derived from the historical experience of the provider group.
- Payment is adjusted annually in line with CPI. Providers can retain margins derived from reduction of inefficiencies.
- Payment is health status adjusted to adequately consider changes in patient morbidity.

b. Dana Gelb Safran, Vice President, Health Care Services, explained the model's quality measures as follows. Measures should collectively advance care such that it is affordable, effective and patient-centered. Clinical performance measures will

include process, outcome and patient care experience measures. They will encompass inpatient and ambulatory care.

- The provider's performance is evaluated in terms of thresholds (or "gates") that are defined in absolute terms, rather than in relative terms. Using relative measurements would result in winners and losers, which is antithetical to BCBSMA's goals. The vision is that the absolute thresholds define good performance and the outer limit captures what is possible to achieve. Where the provider performs with respect to the gates, will determine its level of incentive payments. The contract states targets for the 5-year period of the contract and are structured to incent continued improvement. The use of gates affords "transparency" to providers regarding the full scope of BCBSMA's performance priorities and expectations.
- BCBSMA is using national measures from such sources as HEDIS and JACHO. For each measure BCBSMA sets Gate 1 through Gate 5. Providers coming into this payment model are taking on the responsibility for outcomes. BCBSMA has triple weighted some measures at the request of early provider participants (diabetes measures, hypertension and cardiovascular disease). Providers cannot be successful under this model without recognizing the importance of primary care. The contract provides the opportunity to develop several new measures, in acknowledgement of the rapidly changing field of quality. BCBSMA has created a mechanism to create new measures. Mt Auburn providers who were seeing a large number of patients being discharged without their lab results suggested the first new measure. They are developing a way to get lab results at the time of discharge. This is changing the dialog between carriers and providers.
- The quality payments providers receive depend on what level the provider is performing. The payout curve rewards early and middle improvement with less increase between gates four and five.

c. Commissioner Questions and Comments:

Question and Comments	**Speaker's Response**
Is behavioral health and pharmacy included under the capitation?	The preferred model includes both. To date we have carved out behavioral health. Pharmacy is included in all contracts and pharmacy benefits are operated through our PBM.
If you are a patient, are you assigned an HMO?	We are applying this currently only to HMO products. The global dollars are linked to providers through the member picking a PCP. The patient will not know that the provider is participating in this new payment model. Providers want more transparency about participating in this type of program. Currently Harvard Vanguard does its own patient education.

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Question and Comments	Speaker's Response
	BCBSMA is willing to help.
When the HMO movement started, it was like a religion and the physicians were true believers. The secondary wave of enrollees hadn't signed up for the religion and when they found out about limits, they got angry. Patient awareness of what they are signing up for is critical.	BCBSMA is talking about what it can do to support more transparency. We believe that the movement to push more cost onto the patients is close to its limit. If patients are offered a choice of a more costly or more restrictive system for less cost where we can show that care is as good as or better than the high deductible plan, we believe many patients will select the more restrictive plan. We need to have a different type of conversation and we need to be open.
How is risk management included in the budget?	The historical budget and trend includes risk management costs.
Is the budget risk adjusted on an individual or panel basis?	It is adjusted on a panel basis.
Why would an entity not want to take stop loss?	All entities take some level of specific stop loss coverage. They may not want aggregate coverage if they are very large and experienced in managing care.
Is there some minimum requirement for stop loss built in?	We won't sign a contract if a certain sized group does not have stop loss coverage.
If a physician group is signing up with a particular hospital to share risk, how does it work if the physician uses different facilities for different services.	BCBSMA says that you can go to anyone in the provider network. We need to move to a different education for patients. We say that you need a physician referral and we need to support that physician's choice. Andrew Dreyfus: The cost of patients going to other facilities than the risk-sharing facility is built into the historical costs, so the entity is not hurt. There is an incentive to keep the care within the integrated group.
How do claims processing work.	If it's a global budget, BCBSMA pays claims and reports back with a year-end settlement. If it is a global payment, BCBSMA will do an estimate of the funds that will stay within the provider system and pay that amount out monthly. We will keep the remaining amount to pay for out of risk-bearing entity claims.
Because BCBSMA is large it has the advantage of a huge database to create statistically sound measurements. How does use of absolute benchmarks address	BCBSMA has relied on national or statewide data, data sets available to all, to create our gates. It is important that the highest gate is a stable number that shows

Question and Comments	Speaker's Response
variability of performance?	up anywhere in the US. We are only using quality data.
What kinds of patients are in your groups.	No answer.
Can this model be expanded to the PPO products, since the HMO enrollment is shrinking?	Yes. The problem is that the PPO does not require members to select a PCP. We know that the vast majority of Americans have PCPs. We have an attribution model that is similar to other models (93% of PCP-member matches were correct). There will always be a segment of the population not receiving care, but in the system. We are working on figuring out how to deal with this segment, and hope to solve the problem in the next year or two.
When and how do employers benefit from this process?	The employer's benefit by having a lower rate of inflation. Even if trend savings are offset by quality payments, there will still be savings from improved health.
We need cost savings. CPI plus (in costs) may still be more than we can afford.	We believe that there is 30% waste in the system. We believe that our model starts to get that reduced. Andrew Dreyfus: BCBSMA has struggled with the question of to whom should the benefit accrue. Our model will cut the trend in half over five years. Employers want to know when it will get to zero. We believe that if physicians and hospitals work collaboratively, we will create an inflection point at which the system will change. There are also opportunities in benefit design to direct members to high value services, which may produce additional savings.
Can the model be effective if it did not start at the current budget amount?	If we want to pay for integration, then we need to provide incentives to integrate.
Some people talk about taking funding out of the system; other focus on improving quality. I look at the end point to be to pay the same percent of GDP, but get better outcomes and less disparity. This is targeted at getting more value out of the system, even if the trajectory does not go backwards.	
The obligation of the Commission is to think about helping the Commonwealth (save money) in the relative short term.	The incentives in our model have engaged providers to be involved in what gets into the system. We know that part of the

Question and Comments	Speaker's Response
Remember what happened at Virginia Mason in the West Coast – they reduced costs, but the hospital lost revenue, so the initiative was stopped. We must be intellectually honest that there will be losers and winners. If we don't face up to this, we will have mushy recommendations that won't be responsive. We won't make everyone happy.	reasons for the increased costs is because of new treatments and technologies because there is no way to say no. Traditionally there are no incentives to say no. The BCBSMA model changes the dynamics of the discussion.

4. *Case Study of Global Payment – Patient Choice: Ann Robinow*

The Patient Choice initiative was started in Minnesota in 1995 on behalf of the Buyers Health Care Action Group (BHCAG). It went live in 1997 and is still operating. It was spun off into Patient Choice in 2001 and sold to Medica, a large HMO, in 2004.

The objective of Patient Choice is to use market forces and a new approach to provider payments to force providers to compete by managing costs and improving quality, and by giving consumers incentives and tools to migrate to better performing providers. This was possible in Minnesota because there are several discrete primary care provider systems with only some overlap at the specialty level.

We felt capitation was a non-starter, but wanted global payment incentives. Critical to the incentive was having external market discipline from consumers, otherwise provider would just use clout to maximize global payment amounts.

a. The new approach to payment needed to:
    - Make providers accountable for total population costs.
    - Work with a variety of different provider structures. We were working with a predominance of highly integrated systems, but also with a mix of provider configurations.
    - Work with a variety of plan designs, including high deductible plans.
    - Minimize infrastructure needs and changes.

The program works by having providers organize into systems, which are measured on cost and quality. Providers submit bids based on their expected total costs of care for like patient populations with the same benefit set. Patient Choice created the utilization information by taking data and feeding it into a computer-based model to create historic provider utilization information.

We calculated the total cost of care, and then risk adjusted payments based on patient population, using a standard set of benefits. This created a claim target, which was adjusted based on quality measures. We compared claim targets and created claims bands. We then disseminated information on quality and system capabilities and worked with the employers to create premium bands. The range was enormous. Consumers could then choose to join a provider system based on value. There was transparency of information on care system costs and quality to patients and to payers. Consumer premium and benefit incentives were established by employers to spur

choice of better performing providers. Employers were urged to contribute at the level of the least expensive system.

We used a variable FFS payment approach. Claims were paid on a FFS basis at the submitted prices. Quarterly, we calculated total costs of care using the submitted pricing based on 12 months of history. We compared these costs against the claim target. We then increased or decreased fees based on where the actual costs were compared to the claim target. We did not collect or dispense retroactive payments. Annually we redid the bidding process with a new claims target set, and cost bands created. Consumers then picked their system.

Providers organized into care systems and self defined their referral and hospital networks. Providers created their own brand and market position by demonstrating value to constituents. They could be a gatekeeper or open-access model; they could focus on specific populations or regions; they could set their own price and contract externally for services and they could control their care decisions. For example, providers could use the funds to pay for non-traditional care, such as phone visits.

Our evaluation shows that enrollees have migrated to better performing systems over time.

b. This system differs from capitation in the following ways:
    - Every service is reimbursed.
    - Providers do not receive a pool of dollars prospectively.
    - Providers do not distribute dollars, but the claims payer does.
    - Performance impacts future fee levels and presentation to consumers; there is no retrospective impact.
    - Providers cannot run out of dollars or pocket excess dollars, so there is no windfall or loss of funds.
    - Avoiding sick patients is counterproductive because they drive more revenue; the incentive is to attract sick patients and manage them well.
    - Consolidating for higher payments (through use of clout) is counterproductive.
    - Performance evaluations are risk adjusted.
    - The model can be used for self--funded employers with any benefit style, because of the variable FFS.

c. Patient Choice's key accomplishments are the following:
    - Got providers to organize themselves into mostly discrete systems.
    - Got providers to be accountable to global budgets without bloodshed.
    - Got providers to feel accountable to their patients rather than to health plan executives to explain their high costs to patients.
    - Allowed employees to continue to access higher cost systems, but at a price.
    - Enabled cost conscious employees to lower their costs, which is not possible in a traditional arrangement.

d. Barriers not solved by Patient Choice include:

- We never got a critical mass of patients needed to drive substantive change, especially in provider investment strategies.
- Employers were reluctant to hold employees accountable for their choices. They did not want employees to bear the actuarial cost differences, and were nervous about the cost to employees of buying up to a higher cost plan.
- A number of employers who were large national accounts were reluctant to do anything different in a single market.
- There was resistance to change at every level. In particular, employers and plans did not like change, although many consumers were comfortable with change.

e. The lessons learned include:
   - Change is really hard, but possible.
   - Providers can be accurately differentiated and stratified.
   - Lower prices do not necessarily mean lower costs.
   - Consumers will respond to financial and quality variation.
   - One can build on the current FFS system using existing claim systems to drive appropriate resource use.
   - Smaller provider entities can participate if they are not subject to insurance, but still accountable for total care of their patients.
   - Data integrity is crucial to the process and to get buy-in. We had some bumps along the way.
   - Change requires strong administrative capabilities.
   - Change creates winners and losers and losers will undermine the process, while good performers like it.
   - You need a critical mass to drive provider investments, but just leveraging variation can create savings.
   - Patient Choice is harder to explain and sell than standard products.

f. In asking the question whether a model like Patient Choice could be done in Massachusetts, Ann offered the following observations:
   - National employers are looking for all-at-once national solutions. This model requires local attention and provider interaction. It cannot be dropped wholesale on the entire country.
   - It is easiest to implement in markets with some degree of physician organization, verses solo or very small practices. Solo practices need some degree of vertical organization.
   - This model can be modified for smaller, less organized markets by banding provider types (PCPs, specialists and hospitals) separately.
   - It can bridge and combine with more granular approaches to reimbursement, such as episodes of care payments. Episodes of care payments must be done within a total over-all cost target or limit.
   - Plans within the target market must create similar products.
   - This model may work best in an individual market, rather than in a group market, since employees are open to change more than employers are.

- Current market conditions are creating renewed interest in this type of solution. I am referring specifically to the Minnesota health reform legislation. There is also some national interest in the Patient Choice model.

g. Commissioner Questions and Comments:

Question and Comments	Speaker's Response
Are there any minimum requirements for provider IT infrastructure?	There were no requirements. We look at the providers' ability to manage through the continuum of care. There was only one entity that could not meet the request, which was the U of Minnesota Medical Center. They made changes and joined later.
How did you deal with rural areas when patients can't chose because there are no other doctors available or are not taking more patients.	We did not see this as a problem. All people had insurance and were desirable patients. For rural providers, we still calculated all information and used the same approach. Rural employers used their relationship with providers to show them that they were not performing at levels expected and insisting that patients be sent to other specialists. This had an impact. It is not as effective as real competition, but it was an important influence.
What did you do when tertiary hospitals are buying practices and incentivizing PCPs to send patients to tertiary hospitals?	Under this model, the system still had to prove that sending patients to premium providers was resulting in value. We saw high cost systems lower their costs.
Wouldn't consolidation eliminate competition?	Providers organized more around optimizing resources, rather than to gain clout. The consolidated systems were not the best performers. Small PCP groups that could turn on a dime regarding where to admit or which specialists to use were most successful. Integrated systems can have lots of overhead.

How does this model look to consumers?	Most employers would charge a premium based on the cost of the system. Some employers varied co-pays based on cost of the system. We wanted to have the actuarial value to be reflected in what consumers paid, which is easier to do with premiums than with co-pays. We did not see a correlation between price and quality. We believe that the total cost of care (resource use) is a quality measure.
What was your market share? What is BCBSMA's market share?	Market share was 10% initially. It then shrunk as insurers bought back clients. Patrick Gilligan: BCBSMA's market share is 25% on average. To implement change, you still need a larger chunk of the market, including Medicare and Medicaid.
Was the total cost trending down?	Trend was about 2% lower than market trend. The migration to lower cost providers was the reason for the lower trend.
When I was part of the Massachusetts Health Care Purchasers Group we tried to promote Patient Choice in Massachusetts. Providers and plans were against it and we could not get any traction. Change was terrifying and they could not come to grips with the idea of disrupting the existing system. I think that timing is better for change now – the status quo is not working.	I suggest that you work through plans to get traction with providers and employers. In Minnesota, provider organizations are recognizing just in the last month or two that "the jig is up" and are starting to make their own changes.
What was the plan landscape in Minnesota when you rolled this out?	We had three dominant not-for-profit plans that saw this as competition. Part of our problem was timing. Consumer Driven Health Plans were coming out and Patient Choice was more difficult to explain.
Were practices involved in serving employer-based patients?	Patient Choice was for self-insured employers. The State of Minnesota runs a similar program successfully. This has not been implemented with Medicaid. You would need to be more creative regarding incentives if it were to be implemented for Medicaid.

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5. *Overview of Global Budgets – Deborah Chollet*

Deborah Chollet presented the following information regarding global budgets.

A global budget places a maximum on total expenditures made by some or all payers. Global budgets apply to a defined set of services and are intended to limit total expenditures for care. There are several system-wide examples. Canada and the UK set global budgets at the government level. In the U.S. Medicaid and SCHIP block grants are global budgets; the VA services are provided under a global budget and the Medicare sustainable growth rate targets are global budgets that Congress does not sustain.

There are no direct incentives. Incentives vary with "flow down" provider payment provisions. In practice, experience suggests that global budgets reduce or slow delivery of services, which if waste is not a bad thing. They also create longer queues or waiting periods for non-emergency services. Managing queues is a very important issue.

Planning and operating a global budget implies that there will be regulation of provider payment and/or premiums. Regulation is direct if associated with payments. Payers have little experience managing this flow down. There must be systems of monitoring and measuring cost in real time. Last years dollars are not good enough. Canada and the UK own the assets so the costs are known. There must be an ability to manage patient queues without adverse impacts or outcomes. Finally, there must be sustained political will. The system requires predictability. There must be some distance between decisions and politics. There needs to be an independent or quasi-independent board to administer the system.

Question and Comments	Speaker's Response
Conventional wisdom regarding global budgets is that people have to wait long periods to get needed care.	One must distinguish between emergency and elective services. Emergency services will be provided without queues.
Is Patient Choice an episode of care model?	It is a global budget that impacts fee-for-service levels.

The meeting ended at 2:00 p.m.

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Meeting Date, Time, and Location

Date: Friday, April 3, 2009
Time: 12:00 – 5:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors and DHCFP Staff
√ Leslie Kirwan (co-chair) √ Sarah Iselin (co-chair) √ Alice Coombs, MD √ Andrew Dreyfus √ Deborah C. Enos √ Nancy Kane √ Dolores Mitchell √ Richard T. Moore √ Lynn Nicholas √ Harriett Stanley	√ Michael Bailit, Bailit Health Purchasing, LLC √ Steve McCabe, DHCFP √ Michael Grenier, DHCFP	√ Michael Bailit, Bailit Health Purchasing, LLC √ Bob Schmitz, Mathematica Policy Research, Inc. √ Margaret Houy, Bailit Health Purchasing, LLC

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Co-Chair Leslie Kirwan began the meeting by reminding participants that this meeting represents an important transition, moving from learning to policy development. She further reminded the participants that the Commission is charged with recommending reforms to payment methodologies that will provide better care. She described care as fragmented and not always evidence based, with costs that are not sustainable. The current fee-for-service (FFS) payment system is not solely responsible for the problems, but contributes by encouraging volume and not evidence based care. She believes that there is currently a unique window to develop a better approach. She believes that Massachusetts is under a microscope with Washington, DC looking to see if what Massachusetts does is viable nationally. She urged the Commissioners not to shrink from being bold, saying that the circumstances require it. There are many concerns about implementation as the system transitions from the current state to a new vision. She urged everyone to stay at the table to listen and think about the issues and migration stages. She wants the Commission to recommend more than incremental changes. She urged everyone to set their sights high, identify roadblocks and think about how to address them.

Co-Chair Sarah Iselin reviewed what the Commission is trying to accomplish over the next several weeks in order to meet the goal of developing a report to the Governor and legislature by the end of May. She wants to have the outline of a report by the end of the next meeting (April 10), to then meet with stakeholders to get their feedback, draft the report in more detail, and meet again to refine and finalize the report by the end of May. For today's meeting she is asking Michael Bailit to facilitate several discussions. She then reviewed the order of the agenda. The Commission will be discussing Medicare options next week, which is an important aspect of the Commission's recommendations, since the goal is to have a common payment system for all

payers. She reminded attendees that the only services being carved out of the payment reform recommendations are dental and long-term care services.

1. *Revised Principles – Michael Bailit*
    a. As a result of his latest round of discussions with stakeholders, Michael Bailit is recommending the following changes to the principles:
        - At the request of employers, include the goal of reducing costs, as well as slowing the rate of future growth. As a result of comments from several Commissioners regarding the expectations to reduce costs, it was agreed that the principles would refer to reducing per capita costs, which takes into consideration the realities of a growing elderly population.
        - At the request of the teaching hospitals, the need to fund stand-by capacity costs are separately addressed independent of a discussion of teaching costs.
        - The transparency principle was expanded to make a clear statement that transparency needed to enable patients, providers and purchasers to understand how providers are paid, and what incentives the payment system creates for providers.

    b. Commissioner's Comments and Questions

Comments and Questions	Speaker's Response
I recommend that we add a principle about adequate staffing and funding of government agencies that might be involved in implementing any payment reform. This is often the Achilles' heel of any reform.	Agreed that adequate government agency staffing and resources are important.

2. *Massachusetts Health System: Data Reference – Steve McCabe and Michael Grenier*

The presenters make the following points in their presentation.

The Data Reference was compiled from existing sources, including from health care providers, the Board of Registry of Medicine, and the Massachusetts Healthcare Quality Partnership. The results of the clinical analysis are preliminary; they are going through the clinical validation process. There is limited data available in the public domain regarding physician hospital and group affiliations. The financial information does not reflect the full impact of the economic down turn.

a. The presenters brought the following information to the attention of the Commissioners:
    - Over 1/3rd of the covered population are self-insured. When government programs are removed from the calculation, that number is closer to 50%.
    - Most physicians are paid on a FFS basis; 20% are under some global arrangement, either full or partial.
    - 1/3 of the physicians are PCPs, which is consistent with national statistics.

- 38% of practices have three or more physicians.
- 57% of all payments from one major insurer go to seven physician groups
- Improved care coordination may reduce system costs:
  - 40% of ED visits are preventable, totaling $398.5 million
  - 8% of hospitalizations are preventable, totaling $582 million
  - 7-10% of hospital readmissions are preventable, totaling $576 million

b. The presenter noted that the dollars are not additive, because the studies overlap.
   - All the financial information provided is prior to the financial downturn and does not reflect the impact of the recession. See data starting on page 45 of the document in your packet.
   - The information includes a series of maps, starting on page 63.

c. Commissioner's Comments and Questions

Comments and Questions	Speaker's Response
Do we know how the data on physician payments compares to national information?	No, but I suspect that the payment types vary greatly by region. For example, I would expect there to many more physicians in California to be paid under a global payment system.
Does the data on number of licensed physicians reflect how many are in research vs. patient care?	No.
A national survey done by American Hospital Association members found that between 6.9% and 11.8% of hospitalizations are preventable.	

3. *Strengths and Weaknesses of Reviewed Payment Models – Discussion Facilitated by Michael Bailit*

Following is a summary of the strengths and weaknesses of each payment model reviewed, as articulated by the Commissioners. The Commissioners noted that any payment reform must consider the role of the patient and benefit design.

Fee-for-Service

Strengths	**Weaknesses**
It may be the only feasible option for certain providers, such as: Specialty hospitals, Radiology, anesthesiology, and telemedicine.	It does not support provider responsibility for what they do not do.
It is the only option for medical tourism.	It does not work in terms of meeting the goals of reducing costs and improving

	quality.
It is the status quo and easy.	It does not address the objectives of the Payment Commission.
It could be a transition strategy.	FFS does not always reward quality.
	FFS does not facilitate collaboration.

Episode-Based Payment

Strengths	**Weaknesses**
It aligns hospital, physician and post-acute incentives.	Defining episodes is a complex task.
It is easier for providers to do vis a vis global payment because there is less risk.	It does not address the volume incentive.
It could accelerate learning regarding managing to a global payment.	It is highly complex to apply to co-morbid chronically ill patients.
It could be a transition model.	It is not a holistic approach; it does not integrate care.
	It is too hospital-centric.
	It is unclear that episode-based payments will help with a transition to global payment.

Global Payment

Strengths	**Weaknesses**
It encourages integration and coordination of care.	It needs a strong risk-adjustment feature.
It addresses volume incentive.	It needs to manage risk transfer without increasing costs.
It helps provider groups with an ability to invest and provides flexibility.	It is challenging to apply to an at-risk provider for non-HMO products.
It changes relationships and conversations among stakeholders.	It needs a balancing P4P component to counterbalance potential under utilization incentives.
It exists today in the healthcare market place.	It encourages consolidation.
It supports the role of PCPs.	
It encourages consolidation.	

a. Michael Bailit summarized the discussion by making the following points:
   - FFS with P4P is not where we want to go in the long term.
   - Episode-based payments have some strengths relative to FFS, but the complexities and limitations regarding incentives to forge provider inter-connections limits its usefulness.
   - Global payment has a long lists of strengths, but their needs to be built in incentives for access and quality to counter possible under treatment

incentives. It provides incentives for consolidation, but that could mean a less competitive marketplace. Transfer of risk could be a weakness if not managed well.

4. Stakeholder Recommendations – Michael Bailit

Michael Bailit reported on the results of his second round of meetings with stakeholders to obtain their input regarding payment models that the Commission is considering. Michael, Co-Chair Iselin and members of Co-Chair Kirwan's staff obtained input from hospitals, physicians, consumer advocates, union representatives, employers, community health centers, and health plans.

a. Michael summarized the results of his meetings as follows:
   - General Observations: The stakeholder groups varied significantly in their understanding of the payment model options being considered by the Commission, and this affected the ability of the stakeholder groups to provide informed recommendations. When they did formulate recommendations, these recommendations varied significantly.
   - Community Health Centers: The CHCs were enthusiastic about the medical home model, but wanted a multi-year transition, fearing a quick change might negatively impact them and their low-income patients. They supported a P4P program with common measures. Most participants had negative reaction to global payment, but were more open to the idea of a shared shavings model. They felt that there needed to be separate budget targets for commercial, Medicare, Medicaid and uninsured populations to protect providers serving low income populations, and urged a socioeconomic adjustment to targets.
   - Health Plans: Health plans felt that global payment was the only payment methodology that had been shown to address the inflationary tendencies of fee-for-service payment, and recommended it as a preferred payment model. Because providers are at different stages of ability to take on global payment, they recommended a varied approach to implementation, with risk sharing between providers and health plans, risk-adjustment, possibly different services included within the payment, and some providers moving more quickly to global payment than others. They also advocated getting provider support for the transition. The health plans felt fee-for-service payments should be indexed to Medicare and capped so that they can be no higher than a percentage of Medicare. Further, annual rate increases should be limited so that global payment is financially more attractive than continued use of fee-for-service.
     - Health plans endorsed the use of a common set of pay-for-performance (P4P) measures both for fee-for-service and for global payment arrangements. They felt that P4P amounts should extend up to 10-12%, with greater emphasis on efficiency of care delivery. With regard to medical home, they felt that the concept held promise in theory, but needed to be tested, ideally through a multi-payer statewide collaborative. They also felt that medical home would help primary practices build capacity to succeed under

global payment. Because health plans commonly hold multi-year provider contracts, they felt that government regulatory action would be required to bring about payment reform.

- Employers: Employers and employer organizations were most interested in the concepts of medical home and global payment, and felt that if it were necessary to only offer providers "upside risk", as in a shared savings approach, it would be worthwhile to do so in order to advance a transition away from fee-for-service payment.
    - Employers and employer organizations were of mixed opinion regarding the role of government, and focused on the Commission's principle regarding uniform payment. Some opposed the concept of payment equity, while others expressed openness to the concept, including if there was geographic adjustment and a consideration of the use of rate bands rather than common rates of payment.
    - Finally, employers were interested in how to ensure that employers would realize any savings that might accrue from the changed payment methodology.
- Community Hospitals: The majority of the community hospitals advocated slow incremental change. Specifically, they advocated the use of common DRG methodologies across all payers, and then gradually beginning to test episode-based payment. They believed that the fee-for-service alternatives were not proven and needed to be tested and assessed before adoption. The community hospitals worried about the potential financial impact on their institutions of a quick movement away from fee-for-service.
    - There was one hospital that advocated adoption of global payment and reported that it was having a positive experience with global payment.
- Physicians from Hospital-Affiliated Organizations: Physicians from hospital-affiliated organizations recommended a careful movement to global payment, and felt that in time it could succeed in all geographic areas of the Commonwealth. They specifically recommended attention to:
    - risk adjustment;
    - countering incentives to under-treat with those for access and quality, using transparent performance measures;
    - addressing how the model would account for the prevalence of PPO products;
    - helping providers develop infrastructure to be able to manage under a global payment, and
    - adequacy of the rates.
    - One physician suggested a "shovel ready hybrid" consisting of a portfolio of options for providers at different stages of readiness to transform.
    - This group of physicians expressed the belief that rate equity was an important objective, and that the state should regulate payment rates in order to achieve it.

- These physicians felt that the health plans needed to "give something." They suggested either reducing health plan administrative costs as they delegate functions to providers, or having health plans invest in practice infrastructure.

- Consumer Advocates: The consumer advocates stated that they did not know whether the end goal should be episode-based payments or global payments, but felt it was necessary to go slowly to ensure proper risk adjustment (including socio-economic adjustment) to protect high-risk populations, and to protect against stinting or gaming. They suggested that a first step might be to reduce payment for potentially preventable inpatient complications and readmissions.
  - The consumer advocates recommended that methodologies and measures be clear to consumers, and fully accessible. They felt that this meant not only making information available, but also proactively educating consumers, or paying providers to do so.
  - The advocates support efforts to activate and empower consumers, reduce benefit design cost sharing for primary care and high value services, and support integration with public health through payment reform. They also endorsed the use of consistent measures and metrics across payer P4P programs.
- Physicians from Specialty Societies and Two Large Independent Group
  - This second group of physicians differed significantly in its perspective from community hospitals. They felt that none of the models were proven, and all should be piloted and tested. Only primary care specialty society representatives recommended one strategy for immediate adoption (the medical home).
  - Some of the physicians expressed great fear of the unknown and unpredictable nature of selected alternative methodologies, and especially global payment. They specifically cited the potential adverse financial impact of outliers on practices accepting global payment. The concept of a shared savings approach with no downside risk for the provider was of interest to some, with one suggestion that it be tried using a hospital and its extended staff.
  - In general, this group of physicians felt that efforts to achieve cost savings should focus attention in some areas not directly related to payment. They felt passionately that malpractice reform was necessary to curtail significant over treatment. They also advocated making patients more accountable for managing their own risk factors (e.g., diet and smoking) and adhering to physician-recommended treatment. There was sentiment among a few that states action on malpractice reform would make physicians more open to payment reform.

b. Commissioner's Questions and Commentns:

Comments and Questions	**Speaker's Response**
Is it true that some physicians think that	Yes. They want common rates and

there should be rate equality enforced by a government agency?	common quality indicators.
What was the point made about activated consumers?	It is another strategy to complement our efforts, such as a Value-based Benefit Design Plan. The physicians liked the approach of incenting patients to engage in their own care.
What was the employers' perspective on uniform payment?	There was a split in the group. Some thought that the government should not be setting rates; other thought it was a necessary strategy to be considered.
What does rate equity mean? Does it mean eliminating P4P?	It means equity in a base rate with P4P payments differing, based on performance.
The notion of equity in payment needs further discussion. I heard three variables we could based it on. It is beyond us to assure that each hospital pays physicians the same. We are talking about all payers paying the same for the same service. P4P, geographic equity, risk adjusters all impact payments. We need to know what we are talking about.	
Regarding PCP shortages, this is impacted by levels of payments, lifestyle, how the job is viewed in medical school, etc. We may want to encourage greater use of nurse practitioners.	
Equity is in the eye of the beholder. Everyone is looking at it from their standpoint. Often what we are talking about is the degree to which we want to change distribution, such as only do so with new monies. I am concerned that we are thinking only about changes going forward. We need to remember that cost containment is one of the goals.	
I am saying that payments should not vary by 30 to 40% for the same procedure.	
When we talk about equity, we need to talk about government payments. Among the distortions is that public payers (Medicare and Medicaid) pay less than what providers' costs are. This is a complex discussion.	
This is also a discussion about taxpayer dollars so there must be a balance as to where the dollars go with respect to other	

services the government provides – schools, etc.	
We all have skin in the game. If we use all the dollars on health care, there are no dollars for other services. We need to wring some dollars out of the system. We need to have a sense of urgency.	
I recently met with a large physician group administrator. We talked about the need for more PCP care and the need to move dollars from tertiary care to primary care. This administrator expressed strong support for capitation payments, and said that if a group managed all the care, it could afford to move dollars around.	

5. *Five Critical Questions – Discussion Facilitated by Michael Bailit*

The Commissioners were asked to consider and discuss five critical questions in moving towards a recommendation.

a. Is there one preferred model for the long-term?
   - The Commission agreed that a payment system that had global payment as its predominant payment system was the goal. This would involve a payment to a group of physicians of all specialty types and with one or more hospital and community ancillary providers that were somehow connected. The capitation payments would be made from insurers to these provider groups. The Commission does not want to look at how the dollars are distributed from the group to specific providers, other than a possible exception regarding primary care.
   - There could be various models of provider affiliation. It could be real or virtual. Patients should select a PCP. There must be an explicit relationship between the patient and the physician, acknowledged on both sides.
   - The rate of increase in capitation payments cannot grow at the rate of the current trend.

b. If yes, can the entire delivery system eventually utilize this model?
   - The Commissioners agreed that all providers could eventually utilize this model. It will create more integration and consolidation. There is a need for a transition strategy with alternatives that replicate the best of global payment (reward efficiency and quality) and build capacity to manage under a global payment, but are not preferable to it. Attention will need to be given to how provider groups are built to avoid unintended consequences. Also, Massachusetts does not want to have just one network throughout the state.

c. What needs to be done to support providers and facilitate the transformation

- The Commissioners identified the following activities and resources that would be needed to support providers and facilitate the transformation:
  - Patient education regarding the common belief that more is always better.
  - Transparency regarding payments and payment rules so that patients, providers, insurers, purchasers understand the payment system and incentives.
  - Transparency regarding provider performance so that patients can make informed decisions. Choices need to be tied to benefit design.
  - Providers need transparency regarding information that they need to succeed under a global payment.
  - Health information technology (HIT), including electronic health records, Health Information Exchange (HIE), and informatics.
  - Common dataset and common measures with timely information; an infrastructure and resources to look at the system as a whole.
  - Technical assistance and sharing of best practices among providers.
  - Provider distribution of clinical protocols, to maximize their credibility.
  - Care management capabilities at the practice group level.

d. What role should government play?
   - The Commissioners identified a range of possible roles that government might play in the payment reform process:
     - Facilitating getting people talking.
     - Setting the level of pricing between insurer and provider groups or some role that assures that the payment levels are uniform without suppressing the market's ability to innovate.
     - Fund HIT infrastructure that providers will need to accept global payment.
     - Develop uniform quality improvement metrics.
     - Develop a blended rate for the state or geographic regions so that rates do not result in low payment for some providers based on their patient population.
     - Help persuade the federal government to participate in the system.
     - Increase the number of PCP residency positions.
     - Move comparative effectiveness research forward.
     - Implement an interim determination of need program.
     - Require movement to a global payment because it won't happen quickly otherwise.

e. What needs to be done in the short term?
   - The Commissioners identified a range of possible short-term steps:
     - Consider the role of health plans relative to various government roles.
     - Build PCP capacity.

- Consider restructuring primary care using the regulation and licensing of nurse practitioners and other primary care providers.
- Conduct a pilot study and share results with providers.
- Standardize P4P measures.
- Consider the ERISA implications.
- Freeze rates, but recognize that there is a delicate balance between freezing rates and gaining provider engagement in a move to global payment.
- Conduct outreach and education of providers.
- Reward providers who move faster to global payment, especially those least ready to manage, possibly through grants.
- Align HIT activities with payment reform.
- Increase transparency.
- Make status quo less appealing by introducing a shared savings option.
- Invest FMAP money in transition support.
- State purchasers (GIC and Medicaid) can move towards more global payments, either directly or indirectly.
- Consider whether the existing subsidies to certain hospitals should continue under a global payment system.

6. *Next Steps*

The Commissioners identified the following tasks for the staff and its consultants to pursue so that the Commissioners at the next meeting will be able to consider options.

a. Decide whether the focus of the Commission should be on the short-term or the long-term.
b. Identify the payoffs and rewards that will be realized by going down a path towards global payments.
c. Identify different options regarding the role of government in the different dimensions of the model.
d. Define time sequencing of a transition process.
e. Obtain advice from states with significant global payment experience on how to move forward.
f. Consider medical malpractice reform as a complementary good faith effort.

Co-Chair Leslie Kirwan closed the meeting by stating that she and Co-Chair Sarah Iselin would be identifying assignments for the staff. She also welcomed any thoughts and ideas from members of the audience. She also reminded everyone that the Commission's charge covers all payers and all providers.

The meeting was adjourned at 4:00 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
April 10, 2009

Meeting Date, Time, and Location

Date: Friday, April 10, 2009
Time: 11:00 a.m. – 2:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors
√ Leslie Kirwan (co-chair) √ Sarah Iselin (co-chair) √ Alice Coombs, MD √ Andrew Dreyfus √ Deborah C. Enos √ Nancy Kane √ Dolores Mitchell √ Richard T. Moore √ Lynn Nicholas √ Harriett Stanley	√ Michael Bailit, Bailit Health Purchasing, LLC	√ Michael Bailit, Bailit Health Purchasing, LLC √ Bob Schmitz, Mathematica Policy Research, Inc. √ Deborah Chollet, Mathematica Policy Research, Inc (via telephone) √ Margaret Houy, Bailit Health Purchasing, LLC √ Candace Natoli, Mathematica Policy Research

Meeting Minutes

Co-Chair Sarah Iselin reviewed the accomplishments of the Commission by reminding attendees that at the last meeting on April 3, 2009, the Commission had moved from a learning mode to developing recommendations. She reminded Commission members that by agreeing that global payment is the desired predominant model, they made an important statement regarding the end state vision. She was pleased that commentators and observers had highlighted the Commission's consensus. She characterized the goal of today's meeting as one of focusing on steps to move forward with realistic urgency, nothing that the Commission wants to focus on bold changes, while realizing that we can't move the system overnight. Co-Chair Iselin then reviewed the agenda for today's meeting and introduced Michael Bailit who recapped the April 3 meeting.

1. *Review of Prior Special Commission Meeting – Michael Bailit*
    a. Michael summarized the points of agreement from the April 3, 2009 meeting as follows:
        - The predominant mode of payment will be global payment;
        - Global payments would be made from insurer to provider groups composed of hospitals, physicians and other providers working in coordination. The provider entity would in turn decide how to reimburse its participating providers. Provider groups could be an organization, a virtual system, or a group of contracted providers.
        - The global payment system would include both public and private payers.

- The global payment should include appropriate adjustments, such as clinical case mix, socio economics, and geography.
- Global payment methodology would include performance metrics to encourage case management and access.

b. He indicated that the Commission now needs to develop a transition strategy that would move providers into global payment over time. He warned that the transition strategies could not be too attractive so that they would stop the transition to global payment.

c. He described the current system as fee-for-service with pay-for-performance (FFS with P4P). He asked the Commission members to look at glide paths (to use a term from MedPAC) from the current system to a system of global payments.

d. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
I suggest that the current system is a hybrid of global payment and FFS with P4P. The Commission has been discussing a global payment with quality incentives to avert fears of under treatment. One goal of global payment is to attain a degree of coordinated care.	All Commissioners agreed that the global payment model would have quality incentives/performance incentives.
Simultaneously we need some component of cost reduction wherever we go. If not, we are just putting dollars on top of a system, which we can't afford.	

2. *Review of Key Questions – Michael Bailit Facilitating a Discussion*

<u>What is the transition model or models that will be available to facilitate the transition, since global payment will present a real challenge for many providers?</u>
Michael reviewed the following chart of options and asked the Commissioners whether they wanted to recommend use of one or more in some coordinated fashion to get to the global payment goal:

Strategy	How?	Why?	Experience?
Partial Capitation	• Global payment for physician services only (primary, multi-specialty practice, or IPA), with incentives for decreased inpatient use and for access and quality. • Other providers and services paid fee-for-service.	• Physicians would manage risk over which they have control. • Accelerates risk assumption process relative to shared savings.	• Commonly used model in the past in MA and elsewhere with primary care and multi-specialty practices. • Separate risk pool rewards physician practices for savings in the area of inpatient utilization.
Shared Savings	• Budget target set for all services defined for the payment. Providers share in any generated savings. • Model A: Provider entities comprised of only physicians and hospitals. • Model B: With fully developed provider entities.	• Model A: Simplifies the task of creating and integrating provider entities. • Model B: Accelerates provider entity development. • Both models eliminate downside risk and thus address a major concern for those providers not currently accepting risk.	• Currently being discussed in Washington and considered by MedPAC. • Pilgrim Health Care previously used without great success, but it was not then \utilized as a transition strategy.

Global payment with risk corridors	• Global payment to provider entity. • Model A: Very narrow risk corridors so that provider entities can neither lose nor gain too much initially. • Model B: Disproportionate risk corridors, with a narrow downside and a wider upside.	• Minimizes provider risk exposure while accelerating risk assumption relative to a shared savings model. Risk corridors can be gradually increased over time to fully implement the global payment model.	• Commonly used by Massachusetts health plans today in varied configurations.
Episode-Based Payment (hospital)	• Episode-based payment, including P4P component, is utilized for inpatient services for approximately 10 high volume episodes. • Could be done in combination with partial capitation.	• Could produce shorter-term savings if one believes that it will take significant time to move towards global payment. • Could be utilized within a global payment, i.e., a provider entity could pay its member providers using episode-based payment.	• Previous CMS demonstrations. • Currently being piloted in three geographic markets by PROMETHEUS Payment. • MN currently developing its own episodes. • No experience to date in MA.

a. Commissioner's Comments and Questions:

Comments and Questions	**Speaker's Response**
One other con regarding a shared savings model is that it is built on a FFS payment structure. Physicians will still not be paid for services, such as email communications with patients, since these service are not paid for under FFS. There is diminished flexibility under this model.	Agreed.
In the transition stage we need to understand that not all practices are starting from the same place. There may need to be a menu of options for providers. We don't want those who are ready for global payment to start at a lower point.	Agreed

Special Commission on the Health Care Payment System
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Comments and Questions	Speaker's Response
There would be a possibility of mixing and matching elements from the different models. I like risk corridors, since it is fairer to providers. I find shared savings through partial capitation more iffy because it is still based on FFS.	
Partial capitation does not align physicians and providers. If you want a medical home with something else, a partial cap could be a good way to go. When I spoke with providers, they expressed concern about episodes of care because it is an unknown methodology. Global payment is known and there are ways to get there. We may want to use episodes of care to facilitate reaching a specific goal, such as reducing unnecessary medical readmissions. It will take too long to research,	
I would like to support a menued approach. Performing basic procedures drives the costs of health care. Our length of stay is right in the middle compared to other countries. Episodes of care might be the best way to address use of technology. Global payments with risk corridors might need to be tailored for smaller practices. We don't want small practices to add an FTE to be able to participate in payment models.	
We need one target with multiple starting points. Mixed approach is necessary, since not all practices are ready for global payment. Episodes of care help providers speak across systems and it will be going on nationally with Medicare, so it may be wise to do as everyone else is. I also think that there are some information strategies that can be used sooner – hospitals are focusing on readmission rates because they are being published. Provider groups could be asked to explain performance around certain metrics. The next year, we could pay on these measures, then move up to global payment. We should ask what metrics can we use to change behavior.	
The dollar savings are around high tech procedures, but readmissions are all around chronic admissions. The potential savings regarding high tech services is less than around readmissions.	Prometheus has found that the big dollar savings are around readmissions for chronic conditions.
We can use episodes in conjunction with conditions that use high tech procedures, such as CHF. Provider and institutional behavior will change. There will be more follow-up to keep patients under close surveillance to keep them out of the hospital.	

Comments and Questions	Speaker's Response
It is hard to answer this question without understanding the timeline. Transitions need to be shorter, so we should pick a model that most resembles our goal. Global payment with risk corridors is closest. It gets people to think differently; the others keep the chassis of FFS and we need to get away from FFS. We will have experiments with episodes of care regardless of what we do. It may be used as payment model for types of care, such as specialty hospitals.	

Michael summarized the discussion by noting that interest is strongest with global payment with risk corridors and with episodes of care, if the timeline is longer. Lynn Nicholas asked that FFS with a budgeted target not be ruled out because global payment with risk corridors will not be feasible for some.

How can we support providers?
Michael reviewed the four general categories of support presented in the following chart:

Type of Strategy	What?	Experience?
Performance Measurement	• Identify common pay-for-performance measures and methods.	• CA health plans successfully did so through an independent non-profit organization. • PA recently began such a voluntary process at the initiation of the state.
Health Information Technology and Performance Information	• Make claim data available to provider entities in a manner that will support analysis. o Possibly make analytical tools available to users. • Support electronic health record (EHR) diffusion and implementation. • Develop a state Health Information Exchange.	• NC makes Medicaid claim data available to 14 regional networks, and provides predictive modeling and other software to assist analysis. • A number of insurers in MA and nationally (e.g., Blue Cross plans in HI, RI) have provided financial support to practices to purchase and operate EMRs. • All states are currently developing strategies in response to the federal stimulus funds. Several insurers nationally provide incentives to MDs for EMR adoption.
Patient Education and Engagement	• Engage patients in lifestyle and chronic illness self-management through employer, insurer and public health initiatives. • Publish comparative quality and cost data to allow consumers to make informed choices. • Educate patients about the new payment system.	• To varying degrees many employers and insurers provide education and support for lifestyle change and chronic illness self-management. • VT, MDPH, City of Somerville and other entities have launched health awareness campaigns. • MA HCQCC and MHQP publish quality/cost data.

Technical Assistance (TA)	• Provide TA to providers in the areas of care management, registry and EHR use, data analysis, and entity organization and governance. • Best practice sharing re: global payment.	• Some insurers across the U.S. provide practice coaches to physician practices to support practice redesign and transformation (e.g., Highmark). • Several states are currently providing technical assistance to medical homes in the form of learning collaboratives and practice coaching (e.g., CO, PA, RI, and WA).

b. Commissioners' Comments and Questions:

Comments and Questions	**Speaker's Response**
These all sound good. I have heard from you all about the need to create opportunities for small practices to participate. Is there something that can be in the form of outside support for small practices that would be particularly valuable?	
I suggest IT support, because providers must be of a certain size before covering IT costs. Networking between providers and being able to interchange information is key.	
I also suggest that assistance around governance and how to form entities is important. You can't underestimate the challenge of getting them connected to a group, either actual or virtual.	
Assuming standardized P4P measures, I think that claims data for all payers is very important. To be fair there needs to be transparency about payer reserves, contracted payer payments, claims data, all payer cost data. Because the state is pushing EHRs and order entry for hospitals, it may be possible to coordinate with those initiatives. If practices are going to get money to implement a fuller IT system, maybe an obligation to participate is that a more aggressive payment models should follow.	
Having an all claims database available if very important for providers.	
All these are good ideas, but who is doing what. Giving all providers access to all claims is not useful, because it requires a substantial infrastructure to analyze the database. The state could play an important role in developing an infrastructure to analyze data. Medicare is currently sending out resource profiles around episodes to tell providers how they perform compared to their peers. It helps providers figure out where they are off track. An information strategy could start sooner than later. The legislature or state or voluntary collaborative could encourage Value-based Benefit Design and things like that to motivate patients.	
We need to structure support to be successful. Some organizations may need to be rationalized. In terms of small practices, it is a challenge. Under	

Comments and Questions	Speaker's Response
global payment, there will be increased collaboration among providers. It is part of our future. Global payment is disruptive to providers and plans; plans need to rethink their business models. There is an important role to provide information and support. Providers are hungry to see comparative data to use for improvement. Global payments create more of a partnership between providers and plans, which is good.	
There are some initiatives going on right now, such as the collaborative with 3M to reduce readmissions that will help us get better with the data.	
Somewhere we need to drill down more on the information given to the providers. They need to know what to do differently to change their tier assignment. It is not enough to know they did not do well enough; they need to know what got them there and what they need to do to change. The system gets better if it knows what the relative scores are, how that relates to treating specific patients differently. We need other doctors or pharmacists to show them how to do things differently.	
There are too many measures out there. We need to think what is on the critical path to get to global payment. We should get insights from organizations that have experience with global payment to know what are the three or four items that are critical. The Commission can endorse them and build an enhanced infrastructure. Then we can get to the "nice to have" items.	I will take that as a homework assignment.
We have not talked much about quality measures, standards and coalescing around which will and will not be accepted. We might be well advised to watch what is going on at the national Medicare level. Everyone complains about many standards and measures, but they don't differ that much. They differ in how they are measured and calculated. We need to coalesce around how they are calculated. Get rid of gradations. I think that we need to talk about roles and responsibilities and what an appropriate remediation process is for practices. I do not think that remediation should be done by payers and purchasers alone. It should be the responsibility of the medical group or hospitals. Areas of disagreement could be in the past. The problem will be with small practices without infrastructure.	Global payment creates the infrastructure and incentives to do just that.
There needs to be objective oversight.	
We need to know how we will know that we are successful. We need to identify important levers. Everyone can be working towards goals in different ways; some using shared savings, others global payments. We are not trying to fix everything.	
I do not want to leave the impression with Senator Moore that there is no role for purchasers and measuring. If we use measures approved by providers; that is good. Best practices are not a secret.	

Michael Bailit summarized the discussion by noting that everyone believes that it is necessary to ensure that providers can succeed. The ideas in the table seem to resonate with the Commissioners. The challenge is to prioritize and to figure out where and when the supports should be provided. We will do research and return with information and recommendations regarding who does what and when.

Co-Chair Iselin suggested that the ideas regarding complementary strategies be integrated into this list.

What is the timeframe for the transition?
Michael began the discussion by suggesting a five-year transition plan, such that by the fifth year the healthcare system in Massachusetts would be predominantly paid under global payment. He suggested that there could be a series of planned steps to occur over time, so by year five global payment would be the main strategy for reimbursement. He noted that those who are not integrated will get there later in the five-year period; those who are currently integrated will move there sooner. He further suggested that after the Commission figures out the time frame, then it can identify the sequence of events to get there. He observed that there may be some providers that will never be under a global payment model, and acknowledged that some providers are already there now. He reminded the Commissioners that approximately 20% of current payments are made under a global payment model for commercial insurers in MA; although these models may not have the risk adjustments and financial incentives that the Commission has been discussing. Commissioners' Comments and Questions:

Comments and Questions	**Speaker's Response**
Five years is too long; we need a shorter transition. Also what do we mean by a year? Hospitals, federal and state governments, practices all have different years. How does this relate to the 1115 waiver? I argue for a more condensed time frame with the idea of giving dispensation, if someone doesn't make it.	
I suggest we define an end point – i.e. set a date.	
Maybe we should establish a corridor of time, so that we know clearly where we are going. We could do readiness assessments to determine how feasible our timeframe is. The other factor is how quickly the economy turns around. There are no reserves to make necessary investments now. If the economy turns around, hopefully that will change. We will always have procrastinators.	
We could implement it in phases or waves. Not all hospitals should come in on day 1, but implement it like DRGs were implemented. Hospitals that are most ready go first, then phase it in, learning from the first group.	
We must be careful so that safety net hospitals do not play off against one another by one getting better at managing risk than another.	I suggest that this be phased in by transitional mechanisms and

Comments and Questions	Speaker's Response
	incentives. Those able to move earlier should, and those who are not ready should move later.
Three years is ok; five years is more reasonable. Can we do the things we need to support providers within the next 12 to 18 months?	
We have been surprised at the enthusiasm of doctors and hospitals. Inclusion of Medicare/Medicaid is central. Working in two different systems makes change more difficult. Secondly, we need to discuss disincentives to FFS. We do not want providers on FFS indefinitely. The economic crisis is also an imperative for change – purchasers cannot accept continuing double-digit increases.	
We need to have a date that conveys the urgent situation. Five years sounds long. A big factor is when the clock starts. Everyone needs to do something to change during the timeframe.	
I suggest that three years is more realistic; five has a built-in opportunity to fail.	
We need dual timelines. We need to add ourselves to a timeline. We also need to track what is happening to the fiscal picture and how effectively we are squeezing our dollars. If we are trying to educate consumers, knowing if the strategy is helping their healthcare bills is important.	
The employers and purchasers are going to escalate the timeframe. If it turns out be more cost effective, they are going to start demanding change. Providers will start to move because they will see that if they don't they will lose out.	
Maybe we need a timeline for infrastructure development, then do a timeline for providers, including getting a Medicare waiver.	My suggestion assumed preparation to be part of the 5 years.
We cannot lose sight of urgency. If we can push faster, keeping discipline around the effort is key. This includes political support. We need milestones along the way. The extent that we are not very firm on the end state, then there will be investments in things that aren't aligned with this goal. We need to use disincentives to keep this from happening. We need a clear timetable and achievements.	

How do we advance movement towards global payment?

How do we get movement? What combination of strategies should be used so that we have steady progress on global payment, so there is constant movement over five years so organizations with FFS with P4P move to the transition model then to global payment by our timeframe? We have decided on where it is we want to go. What tools do we need to affect change?

c. Commissioners' Comments and Questions:

Comments and Questions	**Speaker's Response**
We need an entity, such as HCQCC or the Connector to drive the initiative. We may need legislation and stakeholder involvement. Someone has to stay on it.	
We need a new entity specifically for this initiative. HCQCC has a different role and not all stakeholders feel involved. This needs independent oversight. Think about form follows function. This can't be too tightly linked to government because providers will see that decisions are budget driven.	It makes sense to have a new organization that receives the baton from the Commission. However, I'm asking what baton gets passed to this new entity? What impetus needs to be created to push steps forward?
We need to make the status quo less appealing.	
One option is to make FFS unattractive and also address some of the inequity in the current payment system. It could be distracting to spend lots of time; needs to be a simple way to achieve equal pay for equal services. You could have a rule not to go above a target. You could also have a cap on it, not letting FFS grow – all private insurers cannot raise rates. It could be tagged to Medicare rates and converge towards an average. If payments are between 110% and 180% of Medicare, merge towards 150 and hold it there. Make global payment attractive so people will move. This could be implemented by a public agency requiring the adoption of a fee schedule, which might be a reduction in payments for some providers. It would have to be mandatory, not voluntary. If providers are under a global payment and reduce utilization, they can keep the savings and make much better profits. You don't need to increase cap rates.	
You can have a hammer or a feather. What if there were incentives to move to a global payment, such as having up front incentives. Physicians would enroll because of the incentive; they might find getting up front cash more palatable.	

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Comments and Questions	Speaker's Response
One reason the Massachusetts coverage reform was successful, was because it deferred important questions to a state agency with broad representation and with deep staff capabilities. Medicare fee schedule is a complex question. We need some agency to dig deep to determine who is advantaged and disadvantaged. The Commission needs to set out principles and achievement goals. Let the agency make the detailed decisions.	So the Commission would set out the principle of creating FFS disincentives.
Eliminating payment variation would free up resources to do investments. There is going be a need for funds to prime the pump to get to the place we want to go.	
I think government is good most of the time. I don't see how to do what we want to do voluntarily. The market hasn't solved our problems. I know all the negatives about rate setting, but there is an idea of rate setting with a sunset clause with an opt out if the providers move to global payment with proven savings. There ought to be a way to craft something – to give everyone something, but not everyone everything.	
I disagree that money should be taken from those who were successful and given to those who were not. I think we need to guard against just making it a fair playing field. Medicare is a good basis to do things, because it knows how to adjust for acuity and socio economic factors. I haven't talked about teaching component. It is important for Massachusetts to recognize the cost of teaching. To take from those most ready to adopt global payment and give it to other – I just couldn't deliver this message to my constituency. In the course of moving to global payment rebalancing may be ok. It would be based on average costs that are applicable to everyone. I don't want hospitals to fight this. I don't want to just say we will equalize rates over "x" period of time.	How do you think we effectuate change towards global payment? Just because it is the right thing to do? Or More?
Under a new global payment system, per member capitation could be set and be consistent with and based on rationale numbers. It could get adjusted by factors such as socio-economic status or acuity. You get the adjustments or you don't; they can't be negotiated. You can make a more equitable system over time.	Will that result in providers moving to global payment?
I see natural affiliations occurring around delivery system attributes, not because I am interested in joining big daddy because big daddy gets higher rates. Providers will move because we have end points and support. People will begin to move on their own. Statutory requirements are directional, but there will be a need to titrate and adjust over time. We will be more prescriptive over time. It is hard to set firm timelines because of different readiness, but we can't allow providers to sit there and do nothing. Maybe we need to develop pods of activities and people then opt for doing something.	
We are talking about the notion of looking at where providers are now, and	

Comments and Questions	Speaker's Response
pushing them beyond their comfort zone, but not so far that there are access issues in certain parts of the state. We need to individualize the strategy.	
DSH hospitals will have difficulties moving without help. They are mostly government pay and don't have margins in which to invest.	
We are paying a lot now; we can't just add more money for this and wait for reforms. We can't be comfortable just adding money. I understand that there need to be investments.	
We need to think about the impact on primary care workforce. If there are only sticks, lots of physicians who are on the borders would move to other states. We don't want unintended consequences. If we convene a group with all stakeholders, we can sell it better. We don't want to lose focus on health disparities. Physician buy-in is key.	
I don't think a program with only incentives will be effective. We must have disincentives too.	
The only two options I see are 1) making FFS unsustainable by year 5 or have a legislative fiat that providers must be under global payment by year 5. What can be done is a political question.	
We seem to agree that we need a mixed regulatory and market model, and we need some new regulatory oversight to encourage change. I suggest that we ask Michael Bailit to develop two or three ways to effectively balance carrots and sticks.	What about: 1. making FFS uncomfortable; 2. requiring network creation and adoption of global payment 3. setting common method global rates 4. providing incentives to change
With support in place, that is what we have been talking about.	
As long as there is some flexibility regarding #2, that's ok. We haven't talked about short-term impact on insurers. With people losing health insurance coverage, we may want to make health care less expensive sooner by either setting an earlier start date or start cost containment right away.	If we set a date, we will get some change right away because they

Comments and Questions	Speaker's Response
	know they will have to change.
If you are going to global payment system, what's wrong with putting money up front – transferring revenue to up front.	
That is looking at the dollars as capitation payments.	
I urge you to get people in the room who were successful with global payment and those who were not to talk about what it takes to build networks, how long it takes, what is needed to do so successfully and why people failed. Use this information to set an end date. It's about adequacy of payment and adequacy of support and information.	
ITG's offer an example of how a change in payment alone did not result in business model changes. Good faith alone won't bring about change. I am concerned about providers who accept cash and do not participate in governmental programs. We need to include all those practices too. We need to look at how that money will get incorporated into calculations of payments under a global payment model.	
We need to think about the intersection about where our work ends and recommendations about what happens next. Maybe we can make this an important recommendation.	
I think that provider readiness is critical for us to understand. I want the people in the trenches (not the CEOs and CFOs) to weigh in on this question.	
There are several issues that we need to put in the parking lot to consider, including: payments under self insured plans; PPOs; out of state plans offered in MA; and asking stakeholders what support they need, what regulation they would accept and what incentives they would respond to.	
We keep sliding away from the grim reality that FFS is not working. If there is too much money in the system and the pie is too big to sustain, we need to continue asking where the dollars are coming from – who is going to get less and how to do that fairly.	
I think that if we can slow the growth, that equals success. Payment is not the only tool. We can't forget population management and wellness.	
We need to make sure that we address things that are most broken now, such as not enough primary care. If Medicare is a benchmark, we must remember that Medicare over rewards inpatient care and under rewards outpatient care. We need to fiddle around with Medicare ourselves. The behavioral health infrastructure in the state is at the cracking point. The pressure of cuts on things that cross-subsidize the support of mental health means that mental health is crumbling. We need to address behavioral health and substance abuse. We are going to incur more costs on law enforcement; people are being sent to hospitals as last resort. Any capitation we develop needs to	

Comments and Questions	Speaker's Response
address this sector.	

Michael summarized the key points of the discussion as follows:

- The Commissioners talked about a combination of carrots and sticks. Carrots could be some form of up front incentive to change and could be in the form of infrastructure. Disincentives could be eventually making FFS and transitional models uncomfortable at some point along the three to five year timeline. Disincentives could also be to leave less desirable payment methods alone and set a date to be in a group and under global payment. Providers can proceed at whatever pace they want, just that they must be there by the selected date.
- Global payment is based on a uniform methodology
- There needs to be some regulatory or governmental decision-making
- There needs to be some consequences

Michael clarified that leaving FFS alone means to let it operate as it currently does.

The following discussion of needing consequences ensued.

d. Commissioners' Comments and Questions

Comments and Questions	Speaker's Response
What encompasses consequences?	We don't know. If you set a date, it will be meaningless without consequences.
I think that "or else" is the wrong way to go. A stakeholder group will craft a more palatable approach. 63% of practices in Massachusetts are 2 or 3 person practices; we must think about them. The feeling of coercion is problematic. We must be tenacious about setting benchmarks.	
Why we are invested in payment reform is because of our health reform initiative. There were carrot and sticks. There is coercion in an individual mandate, but its worked. We can't leave this to incentives alone.	There is also agreement that we can't have providers forming entities to fail. We need to provide support.
We also need to calibrate the transition based on where providers are now.	
For small practices, 80% admit to one hospital. It is not that difficult to think	

of creating groups. I would like to discuss the question of who should make those decisions: stakeholders or state government. Providers are not the only stakeholders. Someone needs to be accountable, which is more like a governmental entity, and not stakeholders. MedPAC has 35 staff working full time all the time; this can't be done on a citizen volunteer basis. Who will keep the bells and whistles going in a public way.	
We need to talk about how to pay for medical education. We need to make sure that it can work. We also need a commitment to payment reform from hospitals that are concerned about this topic. This reform could be so successful, once the paths are set, that the change could occur rapidly. We want to watch out for unintended consequences, and not too much consolidation.	

Michael noted that the number of tools and choices have been whittled down. He will be putting together a few sets of combinations for the Commission to consider.

Michael also posed the question whether there needs to be any boundaries set regarding what the provider entities are. We could have one statewide entity. We could encourage them to be geographically oriented, or around a community hospital? Or should we say providers can aggregate as they want and join as many as each provider wants?

e. The Commissioners all agreed on the following:
   - That there needs to be some general guidelines developed regarding provider entities;
   - That the state must require insured PPO products and self-insured products to require members to select a PCP. The PCP would not have to be a gatekeeper.
   - Michael put on his homework list the question of self-insured plans and who bears the risk.

3. *Options for Working with Medicare*
   a. Michael explained the following with regard to Medicare waiver authority:
      - The Secretary of Health and Human services may provide a waiver of certain Medicare laws and regulations to demonstrate new approaches to provider reimbursement. They may be designed to apply to limited geographic areas, populations, and/or provider types.
      - The process for obtaining a Medicare waiver differs from obtaining a Medicaid waiver: all Medicare waivers are voluntary, anyone can request a waiver, most are initiated as demonstration projects by CMS, and they typically are true demonstrations.
      - Medicare waivers require a project scope and objectives, specific statutes and rules to be waived, spending and enrollment projections, research design, evaluation plan, and details on appropriate safeguards, for example, around quality and access.
      - The Medicare waiver that is most similar to what Massachusetts is considering is Maryland's Medicare Hospital Payment Waiver. Maryland

has operated under a Medicare waiver since 1977 to accommodate its hospital inpatient and outpatient rate setting initiative. Medicare agreed to participate in the system as long as the state meets a two-part test:
    - All other payers participating in the system pay the state-set rates;
    - All rate of growth in Medicare payments to Maryland hospitals form 1981 to the present is not greater than the rate of growth in Medicare payment to hospitals nationally over the same time period.
- Michael offered the following observations:
    - Most Medicare demonstration waivers are mandated by Congress or initiated by CMS. It is less common for CMS to receive and even rarer for CMS to approve Medicare waivers of other origin.
    - Massachusetts is in a unique position, however, to request a state-initiated waiver or to obtain a Congressionally mandated one. Massachusetts can be viewed as a place to lead the way in both reducing the number of uninsured and in containing health care cost growth. The Governor has a strong relationship with the Obama Administration, which can only help.

b. Joe Kirkpatrick, Vice President, Health Care Finance and Managed Care Advocacy at the Massachusetts Hospital Association and a member of the audience, offered the following explanation of a Medicare waiver that Massachusetts had in the early 1980's. From October 1982 through September 1985 Massachusetts had an all payer system based on HA 25. Key elements included a maximum allowable cost and global budget, based on an allocation system. Medicare and Medicaid participated. It turned out to be quite successful. During the interim measurement periods, it indicated that we owed money back. In the end, it resulted in savings of a billion dollars. It ended because of issues regarding how uncompensated care would be reimbursed. Medicare was not willing to make changes to move forward. The sense was that Medicare would not approve an extension. The coalition agreed to drop it. There were changes that allowed continuation of uncompensated care pool going forward, which were continued by Medicaid and the private system.

c. Andrew Dreyfus also noted that this was also the time of the growth of HMOs. Nancy Kane noted that Medicare has difficulty turning a demonstration program into a regular program so you don't go through the demonstration status forever.

d. Co-Chair Iselin summarized the next steps as follows:
    - The next meeting is May 8, which will include discussion of complementary strategies and the homework from today's meeting.
    - Regarding the final report process and timing, we will be drafting the report quickly and will need your responses quickly. We want to meet our ambitious timeline. The last review of the report must be done by May 26. I will have more information at the next meeting.

e. Lynn Nicholas asked about the status of the Commission's Principles and whether the concept of reducing costs on a per capita basis would be included. Michael stated that it will be included, and that he is working on finalizing the principles this week.

The meeting was adjourned at 1:55 p.m.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
May 8, 2009

Meeting Date, Time, and Location

Date: Friday, May 8, 2009
Time: 11:00 a.m. - 2:00 p.m.
Place: One Ashburton Place, Boston, MA 02108

Meeting Attendees

Commission Members	Speakers	Contractors
√ Leslie Kirwan (co-chair) √ Sarah Iselin (co-chair) √ Alice Coombs, MD √ Andrew Dreyfus √ Deborah C. Enos √ Nancy Kane √ Dolores Mitchell √ Lynn Nicholas √ Harriett Stanley	√ Michael Bailit, Bailit Health Purchasing, LLC	√ Michael Bailit, Bailit Health Purchasing, LLC √ Bob Schmitz, Mathematica Policy Research, Inc. √ Margaret Houy, Bailit Health Purchasing, LLC √ Candace Natoli, Mathematica Policy Research

Meeting Minutes
Co-Chair Kirwan opened the meeting by reminding Commissioners that this was the eighth meeting of the Health Care Payment Reform Commission. She remarked that the Commission has made great progress in transitioning from our current payment system by identifying global payment as the recommended model of payment for the new system. She mentioned the recent Boston Globe article as evidence of the level of attention the Commission's work is receiving. She explained that the focus of today's meeting is how to make the transition from current payment methods to a global payment system.

Co-Chair Iselin reviewed each agenda item, which focuses on establishing a framework for the transition. She reminded the Commissioners that additional details would need to be worked out through the process of drafting the final report, which she envisions as an iterative process over the next month or two. As a result of scheduling conflicts, Co-Chair Iselin explained that the last Commission meeting would be moved towards the end of June. She explained to the Commissioners that if they get bogged down in details today, she would take the liberty of moving the meeting forward and those issues of concern in a 'parking lot' would be discussed in further detail during the drafting process.

1. *Review of Third Round of Stakeholder Meetings – Michael Bailit*
    a. Michael explained that during this round of stakeholder meetings he sought stakeholder input regarding the Commission's draft recommendations to date. He posed two questions to the stakeholders: what advice they had for the Commission regarding the amount of the global payment and residual fee-

for-service should be determined, and what was viewed as necessary in order to effect this transition to global payment.

b. Michael spoke with nine stakeholder groups during this round of engagement, as well as consulting with the Health Care Quality and Cost Council. Michael explained that since providers are more familiar and comfortable with the term "Accountable Care Organization," (ACO) he is no longer is going to use the term "provider entity" to describe the networks of physicians and providers that will be formed under the new system. The following are the key points made by the stakeholders:
    - In general there was a range of responses, even within stakeholder groups. Regarding how rates would be determined, the responses varied from no role for government to government setting rates. Some stakeholders sought a middle ground where the government would help set some parameters, but did not define the degree of government involvement.
    - Regarding the question of how best to effectively transition to a global payment system, stakeholders generally did not see a purely voluntary approach as workable. They noted that there was an inherent need for some degree of incentives and requirements. Other stakeholders wanted to tie incentives to technical assistance or IT services.
    - *Community health centers (CHCs)* were surprised at the direction taken by the Commission. They had many questions about how a system of global payment would work, and the operational implications for CHCs. Their greatest concern was the ability of the CHCs to obtain adequate fees from the ACO. CHCs feared that hospitals would dominate ACO governance and would favor themselves when determining ACO payment terms. The CHCs raised the following concerns:
        - The impact of eligibility and enrollment churning in MassHealth and Commonwealth Care;
        - The need for health information technology to support providers so that they can report performance relative to measurement standards;
        - The implications on the federal requirement of CHCs that they have an independent board if they are to receive federal grant payments, and
        - That risk adjustment is performed not only at the ACO level, but also within the ACO at the provider level.
    - In addition, the CHCs raised the following questions:
        - What would be the implications for CHCs that refer to multiple hospitals?
        - How would the socio-economic adjustment to the rate be performed?
        - At what rate would non-ACO providers be compensated when patients receive care outside of the ACO?

- How would the safety net be treated? (Two CHC executive directors urged that CHCs be exempt altogether.)

- *Employers and employer organizations* generally supported a movement from fee-for-service to global payment. They had a number of questions, however, as they tried to understand the implications of the draft recommendations. Of great importance to them was whether a system of global payment would require changes to employer health benefit design. Michael Bailit explained that it would not, although voluntary employer benefit design changes could complement the payment design change.
- They also took note of the likely impact that the recommendations would have on the organization of the delivery system, and wondered what impact, if any, federal health reform efforts would have on the Commission's recommendations. Finally, they noted that given the complexity of the transition, and the risk of unintended consequences, time should be taken to ensure a successful transformation.

Question	**Response of Employers and Employer Organizations**
How should payment amounts be determined?	A system of regulated rates is not preferred. Instead, a system that generated cost savings to employers should be pursued, without a lot of regulation.
How should movement towards global payment be effected?	Initial efforts should directly affect only government payers: a) Pursue a Medicare waiver b) Begin payment reform by government payers.

- Physicians from specialty societies and two large independent groups were also surprised with the Commission's initial draft recommendations and concerned that they might cause a repeat of Massachusetts' early experience with physician capitation. Specific concerns voiced by meeting attendees were as follows:
  - Pending federal reform action may supersede any state-based initiative;
  - Concern with the lack of recommendations that address consumer-demand for services. The physicians feared facing financial incentives for efficient care delivery when patients lacked any of the same incentives, and were concerned about the resulting potential for conflict;
  - Legal protections allowing physicians to create ACOs and enter into payment discussions with them (i.e. anti-trust issues);

- Being forced to pay excessive fee-for-service rates for care delivered by non-ACO providers;
- The need to negotiate who would be a member of a given ACO;
- Expenses related to ACO formation;
- An overly aggressive timeline without opportunity for first piloting and testing;
- ACOs would save money, and then payers would decrease rates so that providers can no longer earn a margin, and
- The creation of mini-bureaucracies at the ACO level.

- This group of physicians also raised some questions:
  - How would rates be determined?
  - What would be done to make primary care more attractive?
  - How would ACOs be defined?

- The physicians recommended the following to the Commission:
  - Create Department of Insurance (DOI) regulations for insured products that support value-based benefit design concepts, including reduced or eliminated cost sharing for primary care and screening, and increased cost sharing for patients who receive care outside of the ACO.
  - Ensure that ACOs have a governing body with representative providers on it.
  - Stop the creep of large delivery systems into communities that already have sufficient service capacity.
  - Support the pursuit of administrative simplification, including adoption of common coding and billing procedures.

Question	**Response of Physician Specialty Societies and Two Large Independent Groups**
How should payment amounts be determined?	The state should set the global payment rates and residual fee-for-service rates, the latter to protect the ACOs in the event of patient "leakage" out of the ACO. Global payment rates should include common pay-for-performance metrics.

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Question	Response of Physician Specialty Societies and Two Large Independent Groups
How should movement towards global payment be effected?	Four suggestions were offered: a) Encourage provider systems with capacity to transition to do so right away b) Assist newly formed ACOs to build capacity before having them transition c) Encourage pilot demonstrations d) Use enhanced payment and Electronic Medical Records (EMRs) as financial incentives for providers to form ACOs.

- Physicians from hospital-affiliated organizations were more predisposed toward the Commission's recommended direction. The group liked the idea of having an independent entity facilitate and oversee the transition and implementation process; they noted that getting physicians to trust a government entity would be a great challenge. The group also supported the notion of uniform performance measures and performance measurement. They noted that while global payment to ACOs might be the right direction, it would not be easy.

- Similar to other stakeholder groups, the physicians offered concerns, questions and recommendations:
  - Insurers may respond by staffing up and increasing administrative costs rather than by decreasing them.
  - Physicians who do not like the new model may make disparaging comments regarding the reform to patients.
  - Physicians may not trust state government to responsibly or effectively use data.

- This group of physicians raised the following questions:
  - What rates would apply to patients who are not Massachusetts residents?
  - How soon can the change occur when we gave existing insurer-provider contracts that last five years and have just begun?

- The physicians recommended the following to the Commission:
  - Address the need for tort reform, and use this as a "carrot" for physicians.
  - Effect changes in benefit plan design that will support the new payment model, such as a point-of-service benefit design organized around the ACO.

- Stop the GIC's tiering as a means to gain the good will of physicians.
- Pursue an educational campaign to garner provider support. For example:
    - Have state government educate patents about the rationale for the change and that it is necessary to address the $18,000 annual cost for a family premium;
    - Engage the Massachusetts Medical Society to help get physicians and hospitals on board, and
    - Develop a messaging strategy that identifies what physicians will gain through their participation (e.g., decreased "utilization management hassles")
    - Have the Governor play a leadership role.

Question	Response of Physicians from Hospital-Affiliated Organizations
How should payment amounts be determined?	Provider payment should be uniform, with risk-adjustment. Opinions were mixed regarding whether: a) The state should set rates so that payment was uniform across payers and providers. b) The state should not set rates, but only ensure that every payer paid every ACO a common (risk-adjusted) amount.
How should movement towards global payment be effected?	Three suggestions were offered: a) Create a legislative requirement for change (one individual suggested initially requiring unorganized providers to form ACOs and perform care management with a shared savings arrangement, while requiring organized systems to move directly to global payment) b) Hold down the growth of fee-for-service rates to motivate slow movement to global payment c) Use carrots, such as offering infrastructure support and/or tort reform only to those providers who make the transition.

- Consumer advocates and organized labor. Health Care for All provided its recommendations for the patient's role in health care reform, including tying payment to performance on patient empowerment measures, and the need for patient education and involvement, among other ideas. The group noted in the discussion of ACO "downside risk", that there cannot be any such "downside risk" for patients if the transition is to be successful.

Question	Response of Consumer Advocates and Organized Labor
How should payment amounts be determined?	There was universal support for a strong role for government, meaning either a quasi-public entity like the Connector setting rates, or a state agency operating with an advisory group that would do so. The methodology should be data-driven and transparent, and state-set rates would provide a simpler approach than payer-specific rates. There was some concern voiced about the implications of doing something contrary to Medicare.
How should movement towards global payment be effected?	Several suggestions were offered, with no consensus: a) A bold strategy to motivate movement. b) Holding down fee-for-service rates as an inducement to motivate movement. c) In lieu of forcing providers to make the transition., use health

	information technology dispersion as a reward to those willing to make the transition.

- Community hospital executives offered the following concerns. Specific concerns regarding the creation of an ACO included:
  - Community hospitals lack the wherewithal to create the infrastructure required for an ACO.
  - Unintended consequences are likely to occur.

- The hospital executives raised the following questions:
  - What would be the funding source for infrastructure creation?
  - What are the legal implications of ACOs accepting risk?
  - What would happen if an ACO performs poorly?
- Hospital executives recommended the following to the Commission:
  - Don't restrict all ACO services to a narrow geography. That is, allow ACOs to purchase tertiary care outside of their geographic region, should better value be available elsewhere.
  - Have ACOs fund infrastructure through savings.
  - Make ACOs small enough so that a large bureaucracy is not needed. Consider allowing ACOs with only one community hospital, and don't force marriages between institutions with long-standing poor relations.

Question	**Response of Community Hospitals**
How should payment amounts be determined?	Several alternatives were offered, with no consensus: a) Government needs to set rates in order to ensure equity. b) Government's role should be to set the parameters within which rates would be determined by payers and providers. — for example, setting a ceiling and/or a floor. c) No government involvement initially, with government intervention later only if a market-based approach was found to fail.
How should movement towards global payment be effected?	Several alternatives were offered, with no consensus: a) Provider education should be the primary strategy. b) Use incentives c) The state should set targets or requirements for transition by a defined date, with benchmarks along the way.

- Large teaching and majority safety net hospitals. A couple of hospital executives questioned the basis for the Commission's recommendation to pursue global payment, and the lack of evidence

to support the strategy ("this is just a religious belief"). However, most of the discussion focused on provider questions and specific concerns.

- Specific concerns voiced by meeting attendees were as follows:
  - Potential cost savings should be modeled so that there is some confidence that the movement to global payment will produce savings.
  - The Commission should be less certain about where it wants to go, and initially just target ACO formation and a shared savings payment model.
- The hospitals raised the following questions:
- Would academic medical centers be able to be a part of multiple ACOs?
- What anti-trust protection would be required to allow providers to form ACOs?

- Hospital representatives recommended the following to the Commission:
  - The Commission must address benefit design changes for insured coverage, and recommend changes to self-insured employers so that the Commission's recommendations address both demand and supply.
  - The Commission should ensure that health plan reserves and administrative costs decrease appropriately as the new payment system is implemented. One hospital executive felt that addressing administrative costs should be a top priority.
  - The Commission should have insurers fund efforts to help ACOs develop necessary infrastructure.
  - ACOs should explicitly be required to provide mental health services.
  - There must be active monitoring throughout the transition process, with scheduled pauses to evaluate progress and determine whether and how to proceed into the next phase.

Question	Response of Large Teaching and Majority Safety Net Hospitals
How should payment amounts be determined?	Having government set rates would be necessary if uniformity of payment is a goal. A truly independent body should be formed to perform this function Additional opinions included the following: a) Rates should guarantee a profit and the ability to maintain capital plant and equipment. b) Consideration should be given to regulating hospitals as utilities, and studying how utilities are regulated.
How should movement towards global payment be effected?	Legislation with "teeth" is needed; no other approach would be viable.

- Health plans felt that global payment was the preferred payment methodology, but were concerned about implementation issues. Their primary concern was that some providers might never be able to operate in a system of global payment. They recommended that fee-for-service payment be preserved as a payment option for providers who are unable or unwilling to move to join an ACO receiving global payment, or whose performance is already good on access, quality and cost. Should those providers not perform well on access, quality and cost, however, their fee-for-service rates should be regulated and allowed to grow over time only in a limited fashion.
    - Specific concerns voiced by meeting attendees were as follows:
        - A move to global payment will reduce health plan negotiation leverage and will drive an increase in unit price.
        - There is a need to determine how a non-compliant, socially complex patient would be served under this system.
        - Payment reform could drive primary care physicians out of Massachusetts.
        - Health plan product strategies might be compromised if every payer paid the same price.
    - The health plans raised the following questions:
        - What standards would be applied to ACOs?
        - What are the DOI implications for ACOs?
        - Would payers pass the entire global payment to the ACOs, or will health plans continue to pay claims?
        - What would be the source of funding for ACO and provider infrastructure support?

- Health plan representatives recommended the following to the Commission:
    - There needs to be financial and feasibility modeling to confirm the viability of the final proposed recommendations.
    - Noting that some providers are much better resourced than others, the health plans recommended that infrastructure support be provided based on need, and be delivered by the state, and not the health plans.
    - A new government entity should not be created to oversee implementation. Instead, responsibilities should be split up among existing agencies to ensure coordination, avoid duplication, and prevent the creation of a "runaway entity."
    - The Commission should not wait 3-5 years to fully implement a payment reform change. Action should be taken to achieve some cost savings immediately.

Question	**Response of Health Plans**
How should payment amounts be determined?	Rather than leaving rate setting to the market or government rate setting, take a "middle position" such as government setting a default rate when a payer and ACO cannot reach agreement.
How should movement towards global payment be effected?	The health plan association has not yet decided on a position with respect to this question. However, one individual suggested that state government set targets for movement.

c. Commissioners' Comments and Questions

Comments and Questions	**Speaker's Response**
Aren't Community Health Centers (CHCs) already ACOs?	CHCs do not usually have specialists.
The definition of an ACO is very important. It is BCBSMA's experience that physician practices are accepting payments and then contracting with hospitals. I think that CHCs could be ACOs. I worry about limiting the definition of ACO to a large integrated organization. In many places in the state they do not exist and a limited definition will suppress innovation.	
Were you able to ascertain the views of small practices with 1 or 2 physicians?	In general, there was concern about the level of effort necessary to create ACOs. The two biggest concerns are the need for infrastructure development and the

Comments and Questions	Speaker's Response
	fear of financial loss. The practices were more comfortable with more time to develop ACOs and with no downside risk in the short-term.
We are talking about changing culture. They may be losing the opportunity to practice in small practices.	The implications to the day-to-day operations are not known at this point in time. Specific concerns might arise later.
Old thoughts about global capitation may carry over.	In each meeting with providers, there was a provider in the room who had experience with a global capitation and saw the benefits and discussed the resulting change in behavior. The impact on the discussion was notable.
What form did the recommendations of the health plan to take immediate action to save money take? Do they need state involvement?	They were thinking of limiting growth in FFS rates or capping them. Health plans are the only group making that recommendation. They said that they could not make these changes on their own and needed state involvement.
Health plans voiced the opinion that infrastructure support, oversight and creating an uncomfortable status quo should not be exclusively done by the state or by the health plans. There should be a balance. Also, we are talking about two separate issues: what can be done about creating savings in the current situation, and what is the change in payment reform that should be made. These are two different problems that should be discussed separately.	
It is easy for health plans to recommend quick changes, but they do not need to make the structural changes and build infrastructure.	

d. Michael made the following observations in conclusion:
   - The stakeholders are not focused on if there should be a transition to global payment, but rather focusing on how the transition to global payments will be completed. For providers, the more staged the transition process, the lower the level of anxiety.
   - The more thoughtful the process is managed the fewer concerns that exist.

Special Commission on the Health Care Payment System
Commission Meeting Minutes
May 8, 2009

2. *Review of Key Success Factors in Managing a Global Payment: Michael Bailit*
    a. Michael explained that at the last Commission meeting, the Commissioners requested that he interview providers that have been successful under a global payment system to learn what they thought were the key success factors. Michael reported that two types of research were undertaken. First, four groups were interviewed (Atrius, MACIPA, Fallon Clinic, and Sisters of Mercy Providence). Second, consultants synthesized national research on providers accepting global payment.

    b. The top six critical factors that impacted success under a global payment system identified by the interviewed groups included:
        - Effective care management, including management between PCPs and ancillary care providers.
        - Strong hospital-physician relationships. In many parts of the Commonwealth, these do not exist. The state could help with the creation of these relationships by establishing parameters for these relationships and determining what to do with doctors who have relationships with several hospitals.
        - Access to timely, actionable data.
        - Reimbursement and incentives that include adequate payments to the ACO and providers within the ACO.
        - Consumer involvement strategies.
        - Every patient having an identified PCP.

    c. The synthesis of the national research revealed some similarities and differences with the feedback received from the interviewed groups. The top five success factors according to the research are:
        - The nature of the provider affiliations – what is the nature of the organization, what is the range of services offered, what is the appropriate number of providers? The interviewees discussed none of these issues.
        - The need to develop new functional responsibilities. For example, who is responsible for handling complaints, etc? The Commission has not gone to that level of detail.
        - The need the management and leadership capabilities within the ACO.
        - The need for strong information systems and data. The Commission has discussed this need.
        - The need to develop care coordination capabilities. The Commission has discussed this need.

d. Commissioners' Comments and Questions

Comments and Questions	Speaker's Response
Did anyone who was interviewed talk about the accountability of the ACO?	No, that is the internal business of the ACO. There was discussion about whether the distribution of the global payments was being done fairly.
Did you ask about how to assure the fair distribution of global payments?	No, we did not get that specific.
Were any of the groups more fully integrated with ancillary providers?	Sisters of Mercy Providence is the closest example.
There was a question raised about the responsibility of the ACO. What is the responsibility of the health plan? We need to discuss this issue later.	We have not discussed this topic. At this point in time, we are just sharing the results of the research we did.

3. Proposed Framework for Transitioning to a Global Payment: Michael Bailit

Michael Bailit made the following presentation to the Commissioners, outlining a proposed framework for transitioning to a global payment system.

a. Review of Recommendations

- Movement from predominantly fee-for-service (FFS) payment must occur to promote safe, timely, efficient, effective, equitable, patient-centered care and thereby reduce growth in per capita health care costs.
- Massachusetts will transition to a payment system where global payments to provider networks are the predominant form of reimbursement.
- Global payments should be adjusted for risk and other factors and incorporate common performance measures regarding access, quality and under use.
- Provider networks are "Accountable Care Organizations" (ACOs), which include doctors, other community-based providers, and hospitals collectively capable of providing a full range of services. Relationships among providers can vary (ownership, virtual/contractual).

- Since some Massachusetts providers will face challenges moving away from FFS, a careful transition must occur and offer adequate infrastructure support for providers.
- The transition will occur over a period not to exceed 5 years, though some providers may transition sooner, such that everyone does not wait until year 5 to make the transition.
    - The preferred transition payment model, shared savings, should provide either no risk or limited downside risk for providers that are unable to assume full risk.
    - Transition will include financial incentives for more rapid movement (upside potential increases with movement toward global payment).
    -

b. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
Do ACOs include Medical Homes?	While ACOs do not inherently have to include Medical Homes, functioning as a Medical Home may prove to be a key success factor for ACOs under global payment.
I recommend adding a glossary to the report. There is considerable angst around the term "uniform payments."	This is a great suggestion.
The US Senate Finance Committee is developing guidelines as to what the nature of the sharing should be. To the degree that we can align ourselves with what is coming out of the Committee that would be good.	
Transition is dependent on infrastructure development occurring. We may need a mid-course correction built into the process, so that adjustments can be made if the infrastructure support is not moving as quickly as hoped.	
If the unit price is high enough, there will be little incentive for ACOs to become efficient. We need to wrestle with this issue. Every hospital currently has a P4P quality initiative to earn additional payments. To transition to global payments there needs to be something different – incentives for efficiency. If we don't do this there will not be a new way to practice.	We could not afford for the transition to be stuck in shared savings. We need to develop protections against this happening. Transition only works if it is inevitable that all providers move to global payment.
Shared savings should not become too comfortable of a resting place.	

c. Shared Savings
- The principal features of a "shared savings" model include:
  - Payers and ACOs establish budget targets for the total health spending of ACO's members. Members are assigned to an ACO based on who they select as their PCP.
  - Payers may continue to make payments on a FFS basis.
  - At the end of the year, the actual and target spending are reconciled. If the actual spending is less than the target, and if the ACO has performed adequately on access and quality metrics, the ACO, payers, employers, and consumers share the difference "(shared savings").

d. ACOs
- Formation of ACOs
  - Provider role: Providers will come together to form ACOs that will manage patient care, accept global payments, and allocate payments among its providers.
  - Payer role: Health plans, MassHealth, Commonwealth Care, and Medicare (pending waiver) will contract directly or indirectly (e.g., public payers contract with health plans and health plans) with ACOs in global payment arrangements.
  - Consumer role: Patients will select a PCP of choice to ensure care coordination and support the creation of medical homes.
- Support for ACOs
  - Shared commitment and responsibility are needed among health plans, providers, government, employers, and others to support the formation of ACOs and the transition to global payments. This will include**:**
    - Technical assistance and training on best practices in key competencies, such as governance and contracting, patient-centered care management, health information technology, data analysis, and medical home primary care practice redesign.
    - Access to and analysis of claims data for an ACO's covered population to support analysis of member health, care management, predictive modeling, performance measurement, etc.
    - Patient, provider and employer education regarding the new payment system and its implications for patients.

e. Commissioners' Comments and Questions:

Comments and Questions	**Speaker's Response**
I would like the shared savings concept tied to the consumer. The question is how much of the savings trickle down.	

Comments and Questions	Speaker's Response
I do not want the suggestion that shared savings be tied to the consumer to suggest that the goal is for enrollees to pay more.	We will use the term "ACO" as a placeholder for the type of organization we are talking about, rather than having a fixed definition.
We are also talking about profoundly changing how providers practice. When we talk about the mechanism through which global payment can occur, I do not want to be absolutely wed to one concept of an ACO. I want us to remain flexible.	
I agree, there needs to be great versatility of what an ACO does. There should eventually be shared savings given to employers to reduce premiums at some point.	
The definition of an ACO is critical to the other conversations, because it is tied to what type of infrastructure is offered (is the organization a mini insurer versus a community health center). The question is - providers are transitioning to what?	
Transparency is important and it breeds trust. At some level the data should be transparent to all. As ACOs partner-up or change partners, access to data would be helpful.	Transparency is very important. We need to identify the appropriate matrix to monitor and they need to be transparent.
It is important that the report make it clear that ACOs do not need to do the data analysis themselves, but that this should be provided by an organization that has the capability and expertise to analyze claims data.	Agreed.

f. Transition Oversight
   - A new independent Board will be charged with guiding implementation of the new payment system. Board members must be independent, subject-matter experts (e.g., finance, provider payments, delivery system design, etc.)
   - Responsibilities of the Board include:
     - Defining parameters for ACOs.
     - Analyzing health system data, and providing transparency around this data.
     - Establishing transition milestones, including the possible need for a mid-course correction.
     - Monitoring and determining transition progress.
   - The Board will be supported/staffed by existing state entities or agencies and make decisions in an open and transparent manner.

- The Board will seek broad stakeholder input from providers, health plans, government, employers, and consumers. How this will be done is yet to be defined.

g. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
Establishment of this board is critical to success. An independent board may need to consist of either people who are not from Massachusetts and have no stake in the market here but have an understanding of the issues, or the Board needs to be composed of subject-matter experts that represent stakeholder interests. There needs to be a balance, which ever model is adopted. Having 'not too much' government is important regarding the trust-o-meter.	We will address these issues in the next phase of development.
The board also needs to collect data, develop a data warehouse and make it available.	Or this could be done by one of the existing agencies.
What is the role of health plans? Health plans can provide innovation in this area around providing support and information.	
ACOs will have different levels of expertise, so the support role provided by health plans is important.	
At our next meeting, I think we need to work through whether the board members are paid, hired as consultants, etc. Governance issues are critical. We will want to look carefully at how the Connector works and we may want to emulate it, since it has good characteristics.	This may require significant investments.

h. Development of Global Payments

- The Board will develop parameters for a standard global payment methodology, including adjustments for: clinical risk; socio-economic status; geography, if appropriate; core access and quality incentive measures; and other adjustments, including for unique circumstances such as determining compliance toward transition.
- The market will determine global payment amounts consistent with the Board's methodology.
- Payers may need to utilize residual FFS payments to providers in certain limited circumstances, such as: out-of-ACO provider services, including care delivered to non-MA residents; and a subset of health services that the Board may determine are inappropriate for ACO inclusion.

i. Commissioners' Comments and Questions:

Comments and Questions
I raise a cautionary note when developing a list of exceptions. We don't want an escape tunnel that is bigger than the house. The pressure for exceptions is huge.
There are unique circumstances – graduate medical education and stand-by capacity – that need to be included and paid for.

j. Defining an ACO
- The Board will define the parameters of ACOs, such as:
  - Composition and participation (e.g., which scope of services must be available in/through ACOs, "rules" for participation)
  - Scale of ACO (e.g., market share)
  - Stop-loss and reinsurance protection (risk considerations.

k. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
I do not think that we need to get into this level of detail. This is the responsibility of the new Board.	We should include only the minimum required to assure financial viability and continuation of operation. These were offered only as examples. In the report, we will clearly list these as examples, not as prescriptions.

l. Collecting and Analyzing Data
- In the first year, the Board will collect and analyze data to inform policy-making and the establishment of transition milestones.
- Analysis will include:
  - Percentage of payments made under global payment arrangements;
  - Per capita health care cost trends, including medical vs. administrative cost trends;
  - Payment rate variation among providers and health plans;
  - Financial performance of ACOs, health plans, and sub-providers; and
  - Metrics on access to care, especially for underserved populations.
- The Board will also adopt core common performance measures, e.g., quality, patient satisfaction, and monitor trends.

m. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
This is written as though there is no need for a Board after year one.	The responsibilities of the Board include transition and on-going oversight.

n. Milestone: Progress to Global Payment
- The Board will develop guidelines for shared savings and set annual targets for the market to advance to global payments. Sample metric: Percent of payments made under shared savings and global payment arrangements.
- The Board will monitor market progress to these targets.
- The Board will have authority to intervene if targets are not met. Interventions could include establishing payment rate parameters (e.g., constraining FFS rates).

o. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
I offer a friendly amendment. The Board should make recommendations first and intervene only if necessary. We want the market to have the opportunity to make its own corrections.	
We need to consult with legal counsel to determine what is their power to intervene. This may mean legislation and regulations.	This is homework that we will have to table for this meeting.
I support having benchmarks to show progression. The authority needs to be balanced with "if the necessary infrastructure support is there, then….." We already have a crisis in primary care, so we don not want to chase PCPs away.	
If we are talking about a powerful board, we need to talk about steps. When there is a strong regulatory role, there needs to be solid technical assistance. There is a need have the continuing ability to offer technical assistance.	There is a need to track progress on an ACO-specific basis, similar to what is being done in Pennsylvania on a practice-specific basis.
This would not be a board that meets year 1 and lays out a 5-year plan. The board monitors on an on-going basis and annually revisits its metrics.	
The Board should have the authority to have both financial and non-financial intervention.	

Comments and Questions	Speaker's Response
I do not oppose phasing technical assistance. Chapter 58 asks individuals to do something with penalties – gradual penalties over time. Shared responsibility means penalties for willful non-compliance.	
The consequences under Chapter 58 and consequences for providers under global payment are not the same. Physicians have a choice to leave Massachusetts. We are at the mercy of the providers. We need to make this a nurturing environment.	Penalties are only one tool. The other is in how the parameters for making shared savings are set. They can be set to make shared savings a less attractive alternative. The upside potential goes down.
There is little in this presentation about quality. If there is a limited upside because there is a limited downside, it is hard to reward for quality. This is the most important message. I am worried that if we don't talk about quality, we will get stuck in conversations about rationing.	Wasn't there a comment here about how limited upside would only occur in shared savings (i.e. during transition) so that providers aren't too comfortable there? Were limits in full global payment discussed? (I didn't think so…but)
I agree. So many people at the end of the day will say this is about denying care. If there is more emphasis on quality, we will get more provider buy-in. We need to look ahead before hospitals get into trouble or practices leave. We need a nurturing environment with teeth.	
We know that there are community hospitals in trouble and that if more care moves to an ambulatory setting, the area will be in trouble (for example, Quincy, Carney, and Milton). I think that even if there are no savings in the short-term, it is ok if quality is maintained. You cannot close a hospital and reopen it in the same way it was.	
Many hospitals in the state are in financial trouble, and we still spend more than any other state in the US on health care.	
Maintaining financial health of providers is the wrong focus. We need to hold organizations accountable and if they aren't, then they close. Technology does damage to providers, if they do not adapt. Affordability and quality are the goals.	We need to make sure that we have tools and measures to evaluate the impact of decisions made.

p. Milestone: Payment Equity
   - The Board will set targets for the market to promote greater payment equity. Sample metrics include risk-adjusted global payments to

ACOs; payments to providers within ACOs; payments for lines of service (e.g., primary care, behavioral health, etc.)
- The Board will monitor market progress to these targets.
- The Board will have authority to intervene if targets are not met. Interventions could include establishing payment rate parameters (e.g., constraining FFS rates.)

q. Commissioners' Comments and Questions:

Comments and Questions
Is the market commercial? Public too? We need to clarify this. I think of equity in terms of levels of payment, which is difficult to discuss with the current financial picture.
Are we talking about payments within the ACOs. The Board should not micromanage the ACO.
There are pockets in the state where specialty hospitals will be part of the ACO. There needs to be flexibility for innovation. We need to look at licensure requirements and what different providers are allowed to do. We can take pressure off of acute care by allowing post acute care providers to do more.
Global capitation removes the need for regulatory silos.
Once the ACO is performing, we still need some high level monitoring. Initially the Board needs the authority to decide how funds are spent within the ACO.
I think there is a need for innovation, so the Board should monitor for early warning signs that there are problems. If PCPs are disadvantaged, they all might leave the ACO at once. ACOs will be very different, so we can't make one rule that applies to all. We want to hold ACOs to higher goals, such as paying for care management within the ACO.
If the payment is risk adjusted, that should address some of these problems.

r. Milestone: Per Capita Cost Growth
- The Board will analyze baseline per capita cost trends to set target market growth levels. Sample metric: rate of per capita cost growth; implementation of infrastructure support.
- The Board will monitor market progress to these targets.
- The Board will have authority to intervene if targets are not met. Interventions could include establishing payment rate parameters (e.g., constraining FFS rates.) No state has done this, so we can expect unanticipated consequences. The way to respond is to intervene and make adjustments.

s. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
Earlier we talked about providing assistance with infrastructure. We also have to keep an eye on over-development of resources/facilities/overbuilding. Our own Nancy Kane has done research on the cost of construction on future health care costs.	
How many hospitals have been built in the Commonwealth in the last twenty years?	
The question is not how many hospitals have been built, but how many have been rebuilt. We need to set goals regarding capital payments.	
There are problems of mal-distribution of hospital resources within the state.	
I predict that in the long run that more building will be PCP and community based resources. We need to look at the type of care capacity that is being built.	
Per capita cost trends are not the only measure to use. Premium trends are important to employers.	The milestone should be cost growth. The question is whether there should be a milestone regarding access and quality.
We know that certain populations do not receive appropriate care.	
Access is a key issue along with patient outcomes.	
The fastest way to lose access is to lose health insurance. Slowing growth may result in more access.	
There is a huge investment in the health care delivery system to develop capital. There is no need for new resources, but redistribution of resources. We are not adding more dollars, but redistributing them.	
The question is how many capital projects will be put on the shelf when this report comes out?	

t. Monitoring
- The Board will closely monitor transitions to global payment and have the capacity to make mid-course corrections, if needed.
- The Board will consider implementation of infrastructure support for providers in previously discussed milestone targets.

u. Complementary Strategies

- The following strategies have been identified as important complements to payment reform. These are areas of activity that are beyond the scope of the Commission, but are ones with a potentially large impact on cost:
    - Health plan design: Convene a multi-stakeholder process examining health plan design and promoting the use of high-value care (e.g., no co-pays for chronic care management visits and medications) and discouraging inappropriate care. Aligning provider and consumer incentives was a consistent message from providers.
    - Evidence-based coverage: Convene a multi-stakeholder process to review comparative effectiveness evidence and develop consensus coverage policy based on findings.
    - Consumer engagement: Coordinate and expand existing community, employer, health plan and state efforts to activate patients and promote healthier lifestyles, and improved self-management of chronic illness.
    - Administrative simplification: the important efforts underway (Chapter 305 task force, *HealthyMass* initiative, voluntary efforts involving MMS, MHA, MAHP and EACH) should continue through to fruition.
    - Medical malpractice reform: Providers have cited the need to reform medical malpractice as an important goal to reduce costs in the health care system. Health care costs associated with "defensive medicine" have been cited as a concern. Providers have also indicated that activity on this front will help them support payment reform.
    - Primary care workforce development: With an increased emphasis on medical homes and primary care, efforts are needed to attract and retain PCPs.
    - End-of-Life care: Many stakeholders have cited the need to address end-of-life care and decision-making. The efforts underway through the EOL Expert Panel should continue.

v. Commissioners' Comments and Questions:

Comments and Questions
Please don't convene another taskforce.
I look upon these complementary strategies as a way to consider and diffuse anticipated objections. If we move ahead in the manner we are discussing, so much of it needs legislative action. Hopefully this Commission will play a leadership role in maintaining focus.
Maybe the urgency of payment reform will cause disparate efforts to become more focused.

w. Differences from Prior Capitation Models
- Careful transition period with extensive provider support
- Robust monitoring activities to guard against unintended consequences
- Linked to performance measures with emphasis on patient-centered care
- Improved risk adjustment models
- Health information technology infrastructure support
-

x. Commissioners' Comments and Questions:

Comments and Questions	Speaker's Response
Coalescing around an ACO is also different.	
There is not much in here about what is expected to health plans. What role do they play? Should there be health plan metrics on how they work with ACOs. There is nothing to show that they are playing a role and what role they need to play.	In the report, we will make clear the responsibilities of all the players under the concept of shared responsibility

4. Closing Remarks

Co-Chair lselin stated that the Commission is in a good place. The report will include important refinements, including how payment reform is framed. She told the Commissioners that she expected that the report will go through several iterations and it will be important for everyone reviewing the papers to meet the timelines. Co-Chair Kirwan expressed appreciation for everyone's participation and about the remarkable coming together around these principles.

The meeting was adjourned at 1:15 p.m.